

The New York
Academy of Medicine



The Henry W. and Albert A. Berg Fund

Established 1950









July, 1963 Vol. 50, No. 1



The JOURNAL

of the Florida Medical Association

PROCFFDINGS OF ANNUAL MEETING

President's Address, Robert E. Zellner, M.D.

MEDICAL CARE OF THE AGED, SAMUEL M. DAY, M.D.

EIGHTY-NINTH ANNUAL MEETING, W. DEAN STEWARD, M.D.

OSTFOPATHY, CHAS. J. COLLINS, M.D.



Helps the epileptic to realize his potential DILANTIN® (DIPHENYLHYDANTOIN SODIUM) PARKE-DAVIS



The most effective form of emotional approach remains the demonstraon to the patient that the seizure phenomena can be adequately conolled with anticonvulsant medication."1

present, diphenylhydantoin sodium is generally regarded as the standd in anticonvulsant medication because of its effectiveness in controlng grand mal and psychomotor seizures.2-10 It possesses a wide margin safety, and incidence of side effects is minimal.4 With this agent, rersedation is not a problem.3 Moreover, its use is often accompanied improvement in the patient's memory, intellectual performance, and notional stability.11

dications: Grand mal epilepsy and certain other convulsive states.

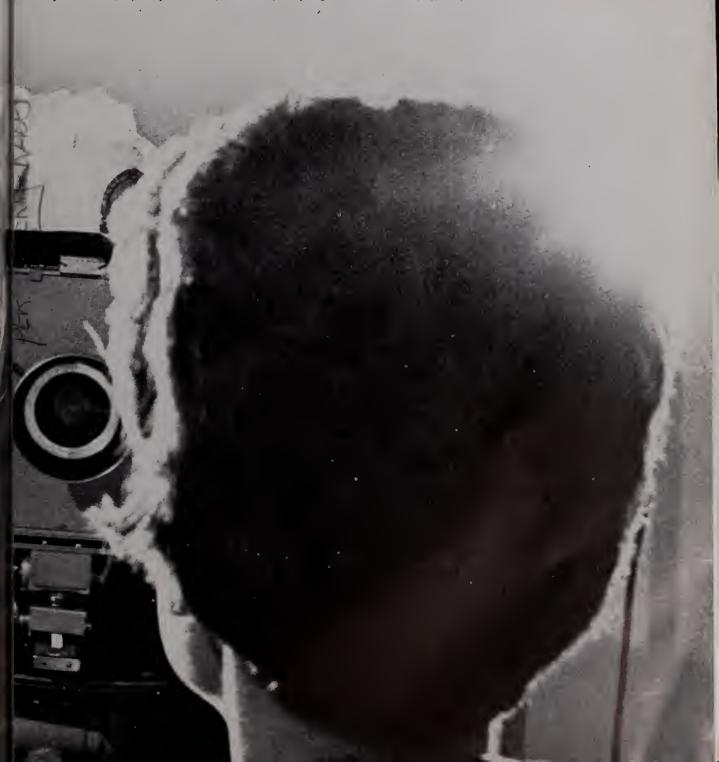
ecautions: Toxic effects are infrequent: allergic phenomena such as blyarthropathy, fever, skin eruptions, and acute generalized morbillirm eruptions with or without fever. Rarely, dermatitis goes on to foliation with hepatitis, and further dosage is contraindicated. Eruptions en usually subside. Though mild and rarely an indication for stopping sage, gingival hypertrophy, hirsutism, and excessive motor activity are casionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia has been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

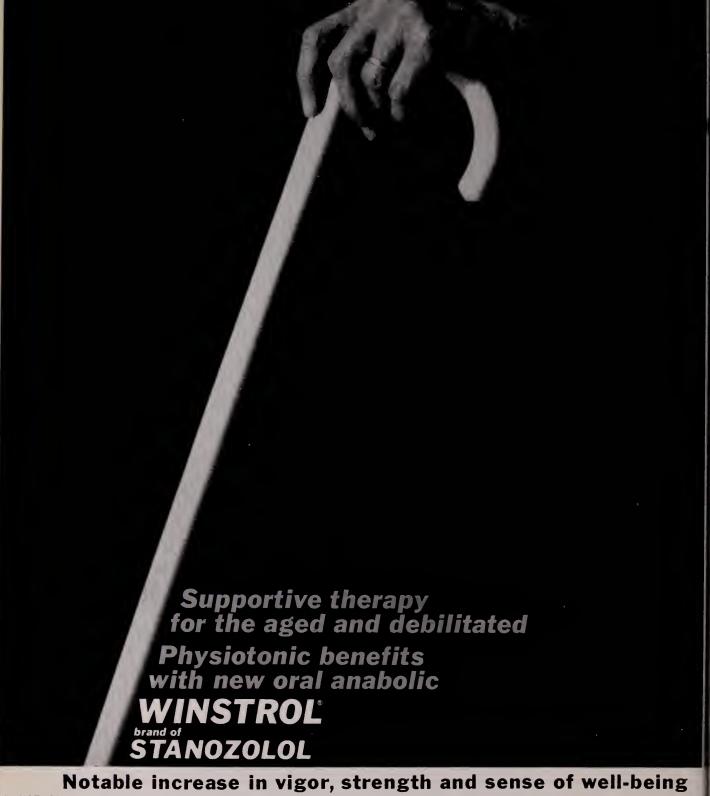
DILANTIN Sodium (diphenylhydantoin sodium) is available in several forms including Kapseals, @ 0.03 Gm. and 0.1 Gm., bottles of 100 and 1,000.

REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. 8:448, 1958. (2) Roseman, E.: Neurology 11:912, 1961. (3) Bray, P. F.: Pediatrics 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: M. Clin. North America 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders (1) Convulsive D

Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

PARKE-DAVIS





WINSTROL (stanozolol-Winthrop), a heterocyclic steroid, combines potent anabolic effects with outstanding tolerance, stimulates appetite and promotes weight gain...restores a positive metabolic balance. It counteracts the catabolic effects of concomitant corticosteroid or ACTH therapy. WINSTROL (stanozolol-Winthrop) rebuilds body tissue while it builds strength, confidence and a sense of well-being in conditions associated with excess protein breakdown, insufficient protein intake and inadequate nitrogen and mineral retention.

Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible, and patients receiving prolonged treatment should be examined and questions.

tioned periodically so that, should side effects appear, the may be reduced or administration of the drug discontinued for In patients with impaired cardiac and renal function, there is sibility of sodium and water retention. Liver function tests may an increase in bromsulphalein retention, particularly in elections. In such cases, therapy should be discontinued. Althougheen used in patients with cancer of the prostate, its mild and activity is considered by some investigators to be a contraint. Dosage: Usual adult dose, I tablet t.i.d. before or with meals women, I tablet b.i.d.; children (school age): up to I tablet t.i.dren (pre-school age): ½ tablet b.i.d. Available as scored to 2 mg. in bottles of IOO. For best results, administer with a high diet.

Marked improvement in appetite / Measurable weight gain

Winth

The JOURNAL

of the Florida Medical Association

Volume 50, Number 1, July 1963

THIS ISSUE

THAD MOSELEY, M.D. Editor

SHALER RICHARDSON, M.D. Editor Emeritus

Assistant Editors

CHARLES K. DONEGAN, M.D. FRANZ H. STEWART, M.D. JOHN M. PACKARD, M.D.

THOMAS R. JARVIS Managing Editor

Louise Rader Assistant Managing Editor

EDITH B. HILL
Editorial Consultant

Published monthly at Jacksonville. Florida. Price \$7.00 a year: single numbers. 70 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3. Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Annual Meeting

President's Address, Robert E. Zellner, M.D.	19
Medical Care of the Aged, Samuel M. Day, M.D.	22
Proceedings of Eighty-Ninth Annual Meeting	28
First House of Delegates	28
Second House of Delegates	32

Editorials

The Eighty-Ninth Annual Meeting	68
Our Relations with Osteopathy, Chas. J. Collins, M.D.	69
Physical Examination for Driver Education Program in the Public Schools, Wilson T. Sowder, M.D.	70

Features

President's Page	
Association News	
Clinical Comment	
News	
Classified	
Schedule of Meetings	
County Medical Societies of Florida	
Florida Medical Association Officers, Councils and Committees	

This Journal is not responsible for the opinions and statements of its contributors. Owned and published by the Florida Medical Association.

LIBRARY

FEB 25 1965

351524

NEW YORK ACADEMY OF MEDICINE Get your
low-back patient
back to work
in days
instead of weeks

You can expect rapid results from 'Soma' (carisoprodol) – because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG, TABLET Q.I.D.

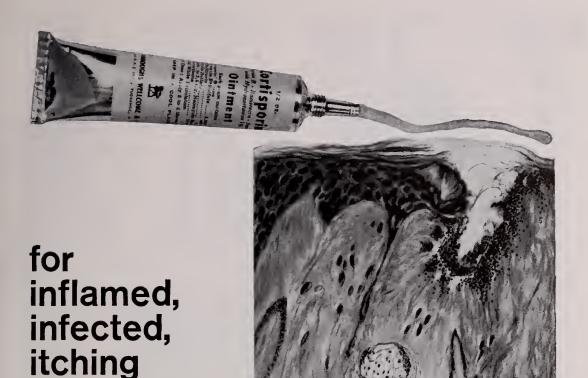
The muscle relaxant with an <u>independent</u> pain-relieving action

Soma[®] carisoprodol



Wallace Laboratories Cranbury, New Jersey





anti-inflammatory / bactericidal / antipruritic

'CORTISPORIN' POLYMYXIN B-BACITRACIN-**NEOMYCIN WITH HYDROCORTISONE 1%** OINTMENT

Each gram contains:

'Aerosporin'® brand Polymyxin B* Sulfate 5.000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg.; Hydrocortisone 10 mg. (1%).

- · relieves pain and itching
- · reduces inflammation and edema

skin lesions

- · provides bactericidal action against most grampositive and gram-negative organisms, including Pseudomonas aeruginosa
- rarely sensitizes

General Indications: Wherever inflammation or infection occurs and is accessible for topical therapy, as in burns, wounds, skin grafts; and plastic proctologic, gynecologic, or general surgical procedures.

Dermatologic Indications: Atopic, contact, stasis, infectious eczematoid, and lichenoid dermatitis: neurodermatitis, eczema, pyoderma; anogenital pruritus; primary dermatoses with or without secondary infection; external otitis:

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Contraindications: Local application is contraindicated in tuberculous conditions of the skin, herpes simplex, vaccinia and varicella.

Available: In tubes of ½ oz. with applicator tip and 1/8 oz. with ophthalmic tip. Although the 1/8 oz. tube is intended for ophthalmic use, it may be used topically.

Complete literature available on request from Professional Services Dept. PML.

U.S. PAT. NOS. 2,565,057 AND 2,695,261



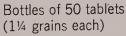
BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

J. Florida M.A./July, 1963



New
Orange Flavored
Bayer Aspirin for Children
is sweet
all the way through,
so children
take it readily.
The GRIP-TIGHT CAP --on the bottle
helps keep them
from taking it
on their own.

Rottles of 50 tablets



NOW! NEW ORANGE FLAVOR!

BAYER ASPIRIN

ORANGE FLAVORED

BAYER ASPIRIN CHILDREN

GRIP-TIGHT CAP (DAYER) GENUIT

We will be pleased to send professional samples on request.

THE BAYER COMPANY
Division of Sterling Drug Inc.
1450 Broadway, New York 18, N.Y.)



The new or early hypertensive patient



The middle-aged hypertensive woman



The geriatric hypertensive patient



The overweight hypertensive patient



When depression or peptic ulcer adds problems



Effective blood pressure regulation for the many faces of hypertension^{1.5}

Important note: For best results with CAPLA (mebutamate)

To demonstrate its bloodpressure-lowering effect, 'Capla' (mebutamate) must have been taken on schedule on the day of the patient's checkup. The maximum hypotensive response occurs within 2-4 hours. Because 'Capla' (mebutamate) is promptly excreted, q.i.d. dosage should be maintained for consistent results. Product Information: 'Capla' (mebutamate) is indicated for control of hypertension, either alone in mild cases, or in conjunction with diuretics or peripherally acting hypotensive agents in more severe cases. Its mild tranquilizing properties are often found an additional benefit to its antihypertensive action.

Drowsiness and occasional lightheadedness, usually transient, are often signs of dosage higher than necessary for therapeutic effect. There are no known contraindications to mebutamate.

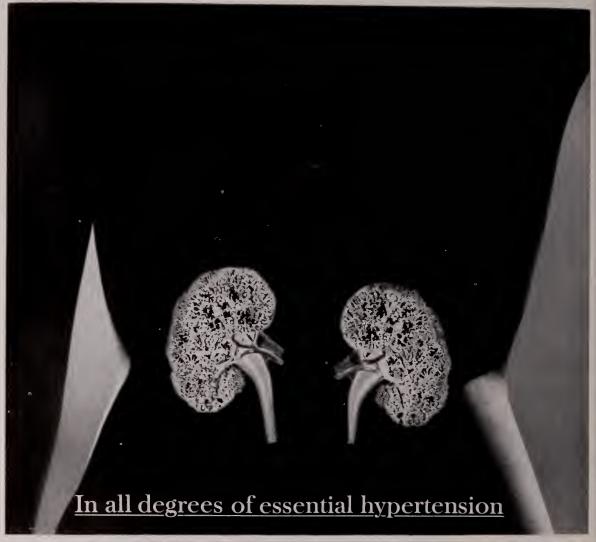
Usual Dosage: One 300 mg. tablet 3 or 4 times daily, before meals and at bedtime. Dosage

should be adjusted to individual requirements; for example, older patients may require lower dosage.

Composition: Each tablet contains mebutamate, 300 mg.

Supplied: Bottles of 100 white, scored tablets. Literature and samples to physicians on request. References: 1. Corcoran, A. C., and Loyke, H. F.: J.A.M.A. 181:1043, Sept. 22, 1962. 2. Costello, A. C.: M. Times 91:53, Jan. 1963. 3. Holloman, J. L. S., Jr.: J. Nat. M. A. 54:94, Jan. 1962. 4. Kheim, T., and Kountz, W. B.: New York J. Med. 62:1596, May 15, 1962. 5. Leslie, C. H.: J. Am. Geriatrics Soc. 10:85, Jan. 1962.

Wallace Laboratories Cranbury, N. J.



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced. "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality." Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients. Rautrax-N is effective in mild, moderate, "A" or severe hypertension. "1.5"

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycos-

uria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N-capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. Rautrax-N Modified-50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief. References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. 9:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. 63:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. 10:516 (June) 1962. (4) Hutchison, L. C.: Chresott Theres.

J. C.: Current Therap. Res. 4:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: 23:248 (June) 1962.

Squibb Quality

-the Priceless Ingredient

squibb Division Olin



RAUTRAX*-N RAUWOLFIA SERPENTINA WHOLE ROOT (50 MG.). BENDROFLUMETHIAZIDE (4 MG.) WITH POTASSIUM CHLORIDE (400 MG.), SQUIBB



Reliable, effective enema

with only 6 cc.?

compact, disposable



As Easy as One-Two-Three



provides rapid, safe cleansing in-

- 1. Surgery: preoperative, postoperative cleansing.
- 2. Obstetrics: during pregnancy, prepartum, postpartum.
- 3. Preparation for x-ray, proctoscopy, sigmoidoscopy where prior catharsis is not possible.
- 4. Simple constipation.
- 5. Atonic constipation.

For comfort and safety

Soft, pliable rectal tube is safe and comfortable; helps prevent local tissue damage. Administered in seconds. Minimizes possibility of cross-infection. Messy clean-up procedures eliminated.

Effective

Hypertonic, blandly surfactant INDEX hydrates and softens the stool . . . initiates gentle peristalsis . . . produces effective evacuation, usually within a few minutes. Absence of bulk especially advantageous in parturient patients. Only minimal inflammation or local irritation noted in adults or children. Not contraindicated for patients on low sodium regimens.





S. Dispose of empty

Economical

Rapid technic saves valuable staff time. Substantially lower in cost than conventional disposable enemas. Demonstrably more economical than soap enemas because no hidden costs of preparation, washing, autoclaving or wrapping.

Administration: Patient should lie on left side, with left knee slightly bent and right leg drawn up. Alternate: knee-chest position. Insert tube into rectum and express contents.

Contraindication: As is the case with any enema, INDEX should not be used in the presence of acute surgical abdominal disease or local inflammation or infection.

Ingredients: Each 6 cc. unit contains Sodium Lauryl Sulfoacetate, Sorbic Acid, Glycerin, Sodium Citrate, Sorbitol, Distilled Water.

Johnson Johnson

New Brunswick, N. J.

ENT PENDING M

P+357A

©1&J 1963

NOW ALSO IN FLAVORED FORM!



BOTTLES OF 4 OZ., 8 OZ., 1 PT. 1 OT.

Antacid-Laxative-Lubricant to help correct constipation

Magnesium Hydroxide plus pure mineral oil make *Haley's M-O* a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and attendant gastric hyperacidity.

The oil globules in *Haley's M-O* are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is thus avoided and a comfortable evacuation is effected through the stimulation of normal intestinal rhythm and blunted defectation reflex.

May we send samples for your evaluation? Just write:

THE CHAS. H. PHILLIPS CO.

Division of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.



STARTING TOMORROW MORNING this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule® brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1½ gr. of ambarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' Spansule capsule taken in the morning.

SIDE EFFECTS: Insomnia, excitability and increased

motor activity are infrequent and ordinarily mild CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories Prescribing information Jan. 1963





For comprehensive control of the whole pain complex... helps the whole patient

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component — chlor-mezanone — 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the whole pain complex, helps the whole patient — with unsurpassed tolerance.

Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily; the dosage suggested for children from 5 to 12 years is 1 tablet three or four times daily. Reactions to Trancogesic have been minor — gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contraindicated in persons known or suspected to have an idiosyncrasy to acetylsalicylic acid. Winthrop Laboratories, New York 18, N. Y.

TRANCOGESIC* CHLORMEZANONE with ASPIRIN



-177810

mu'drane.

the bronchodilator with the intermediate dose of KI

Combination of the four most widely used drugs for treatment of asthma. Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: May be habit forming), Potassium Iodide 195 mg.—compounded for prompt absorption and balanced action, and buffered for tolerance.

Dosage in asthma, emphysema, bronchiectasis, chronic bronchitis: One tablet with a full glass of water, 3 or 4 times a day.

Precautions: The usual precautions for aminophylline-ephedrine-phenobarbital mixtures. Iodides may cause nausea, and very long use may cause goiter. Discontinue if symptoms of iodism develop. Contraindications of Iodides: Tuberculosis, pregnancy (to protect the fetus against possible depression of thyroid activity).

muidrane gg

The Mudrane GG formula is identical to Mudrane except that Glyceryl Guaiacolate, 100 mg. replaces the Potassium Iodide as the mucolytic-expectorant.

Glyceryl Guaiacolate has no known side effects.

Caution: Federal law prohibits dispensing these products without prescription

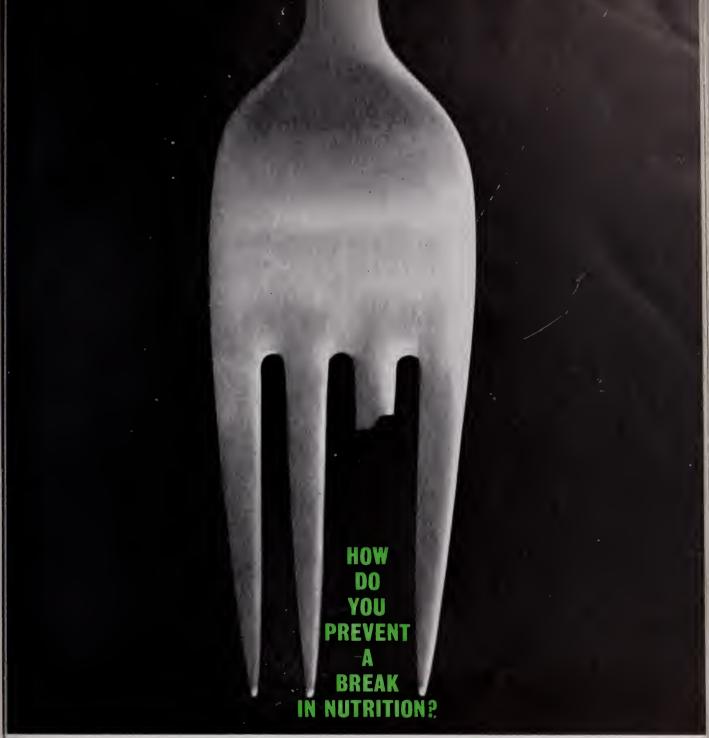
COMPLETE INFORMATION AND CLINICAL SAMPLES SENT UPON REQUEST

Dispensed in bottles of 100 and 1000 tablets



WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VA.

Manufacturers of ethical pharmaceuticals since 1856



capsules ...add Vitamin-Mineral-Nutritional Supplement Lederle

resent-day dieting habits can produce diets insuffient to maintain nutritional well-being. The GEVRAL rmula encompasses vitamins, minerals and hemopietic factors, and is sufficiently comprehensive to impensate for usual dietary inadequacies. y-filled capsules, convenient once-a-day dosage, peal to all patients.

Each capsule contains: Vitamin A Acetate, 5,000 U.S.P. Units; Vitamin D, 500 U.S.P. Units; Vitamin B₁, 5 mg., Vitamin B₂, 5 mg.; Vitamin B₆, 0.5 mg.; Vitamin B₁₂ Crystalline, 1 mcgm.; Vitamin C, 50 mg.; Vitamin E, 10 Int. Units; Niacinamide, 15 mg.; Calcium Pantothenate, 5 mg.; Calcium, 145 mg.; Phosphorus, 110 mg.; Elemental Iron, 10 mg.; Magnesium, 1 mg.; Potassium, 5 mg.; lodine, 0.1 mg.; Copper, 1 mg.; Manganese, 1 mg.; Zinc, 0.5 mg.; Choline Bitartrate, 50 mg.; Inositol, 50 mg.; I-Lysine Monohydrochloride, 25 mg.

Cederle This symbol on the package is your assurance of the highest quality standards.

DERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which 'Miltown' (meprobamate) relieves anxiety and anxious depression has been clinically authenticated time and again during the past eight years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more than any other tranquilizer in the world.

Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or

alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d. Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

the original meprobamate Miltown



WALLACE LABORATORIES / Cranbury, N.J.



in dermatoses amenable to topical steroid therapy

METI-DERM®

Prednisolone, 16.6 mg. in 50 Gm. container and 50 mg. In 150 Gm. container; in nonsensitizing vehicle—Isopropyl myristate with inert propellants—trichloromonofluoromethane, dichlorodifluoromethane.

AEROSOL COVERS

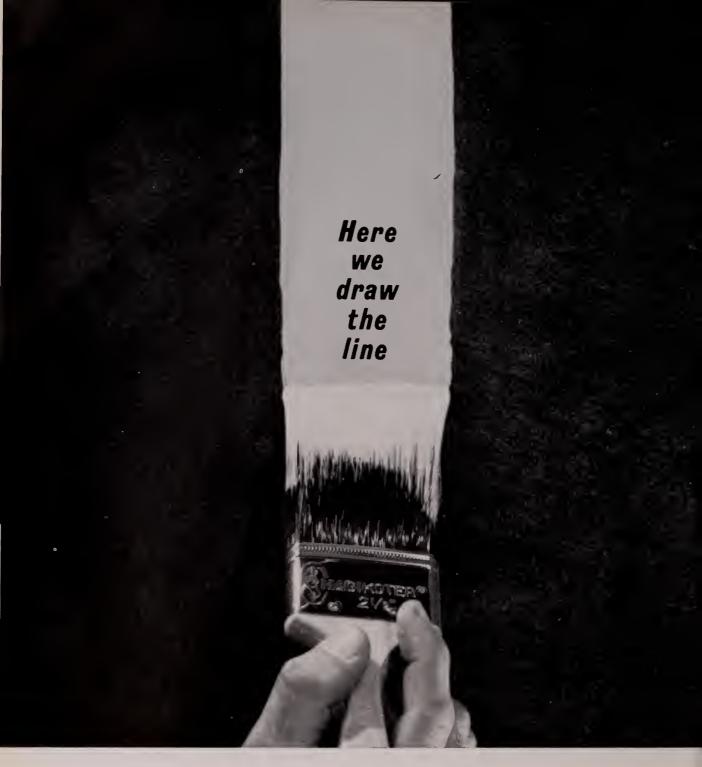
reaches every part of the lesion, any area of involvement • instant cooling, soothing effect • controls the itch, delimits the area of erythema and edema • non-fluorinated—avoids risk of steroid absorption • easy to carry and apply away from home—no residue on the skin

Clinical Considerations: In allergic dermatoses, until the specific causative agent is identified and removed from the patient's environment, the condition may be expected to recur when therapy is terminated. If Infection is present, appropriate antibacterial measures should be taken. METIDERM (prednisolone) Aerosol should not be sprayed around the eyes. Contents of can are not flammable but are under pressure. Containers should be stored in a cool place and neither punctured nor incinerated. For complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey.

® prednisolone topical, Schering.

5.1935





We like visitors. We like to show them our modern equipment and latest research facilities, our exacting manufacturing techniques and unexcelled quality standards. Up to a point, that is. A white line provides the barrier that discourages further exploration. It means look but don't cross. It is a safeguard against inadvertent mishandling or misplacing of products—another precaution in an endless list of rules contributing immeasurably to the quality of the finished product.

Lilly

The JOURNAL

of the Florida Medical Association

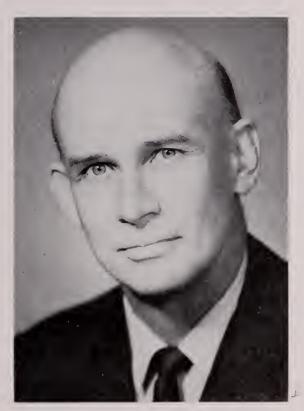
President's Address

ROBERT E. ZELLNER, M.D. ORLANDO

One could not serve in a position of responsibility such as the presidency of the Florida Medical Association without developing, if he did not already have, a sense of history. The trails blazed by my distinguished predecessors have in many instances become well traveled highways leading, rather than to new outposts, to old familiar places. One cannot escape the feeling that much that we do today, decisions which we make now, may very well have far-reaching effects on the practice of medicine not only in Florida but throughout the nation. So it is that as I prepare to turn over the responsibilities of this office to my friend, your President-Elect, I have been thinking about our noble profession, its illustrious past, its future, and the part that you and I play in both.

In just 36 years, seven months, 15 days, and 14 hours, we will be entering a new millennium. To try to postulate what this new millennium will bring to the medical profession would lead to nothing but wild fantasy. Indeed, it is almost as difficult to conceive of the nature of medical practice a thousand years ago. So, to attempt to visualize the future at the equally distant date of the beginning of the fourth millennium is little more than a waste of time. Since we know that change is inevitable as well as to a degree controllable, it is interesting to consider the course of the future for the more limited period of time between the present and the beginning of the next millennium. To do so I would like to take you back an equal period of time to October 1926, just 36 years and seven months ago, for a closer look at history.

You will recall that we had at that time, too, a New Englander for President of the United



Dr. Zellner

States. Probably his most historic pronouncement was, "I do not choose to run for a third term in 1928." The national debt was a puny 17 billion dollars. History has swung full course in that then as now income tax reduction was the topic of the hour. In his message of October 1926, Mr. Coolidge approved a plan to reduce the income tax payments of March 15 and June 15 following as a refund on taxes in excess of Treasury needs. The maximum surtax on income, incidentally, was being cut from 40 to 20 per cent. He opposed the Farm Relief Bill as partly unconstitutional but chiefly because he looked upon its price-fixing stipulations as being economically un-

Read before the Florida Medical Association, Eighty-Ninth Annual Meeting, Hollywood, May 16, 1963.

sound. His invariable conviction that government should not interfere in business lay behind his refusal to take action in the coal strike of 1927. Over half of the cars in the United States were black, because that was Mr. Ford's favorite color, and their dashboards contained an uncomplicated array of two instrument knobs: an ignition switch and a pull choke. Despite the popularity of the Model T, one really had quite a choice of automobiles. Some of you old - timers will remember the Chandler, the Pierce-Arrow, the Overland, the Essex, the Huppmobile, the Willis-Knight, the Graham-Paige, and numerous others which have been joined by the Packard and the DeSoto in the automotive graveyard. The Florida boom was at its height, respectable women were beginning to smoke in public, business was thriving, and a well known governor of New York was beginning to make his bid for the Presidency of the United States. In case you have forgotten, his name was Al Smith. Douglas Fairbanks and Mary Pickford were the idols of the still silent movies, radio was a thing that could be listened to through earphones and what was heard was not as important as the station from which it came, and the hi-fi was a crank machine which produced a thin rendition of Gene Austin singing such songs as "My Blue Heaven."

But what about the doctor? All doctors were just doctors and "specialist" generally meant someone who did ear, nose and throat work. While hormones had been discovered, they were a medical curiosity of little clinical value. There were no blood banks, no antibiotics, no sulfonamides, and vitamins were a newly discovered plaything. The only anesthetic agents in wide usage were ether and chloroform. Hospitals, at least in the public mind, were a place to go to die rather than for a rest or diagnostic procedures. I might add, too, there was no hospitalization or health and accident insurance. Among us here today are those who were practicing in 1926 and who can better describe the conditions than I can since I was still a schoolboy and more interested in geography than in jaundice.

The revolution which has taken place in medical practice in the last 36 years is unequaled in any previous 360 year period in history, and we have no reason to believe that the next 36 years in this millennium will witness changes of lesser magnitude. What will this mean to the future of medical practice? No one can answer this question with any degree of accuracy because so many

factors are unpredictable and uncontrollable. Some factors, however, over which we do have some measure of control, may have a very strong bearing on the future of medical practice, and it is to these that I would direct your attention today.

There are those who contend that the private, individual practice of medicine is anachronistic, that it is too costly, too inefficient, too outmoded. They point to the demise of the semi-independent handcraftsman of a century ago with the rise of the Industrial Revolution. They remind us of the disappearance in our own lifetime of the one horse farm, of the "tailormade" suit, of custombuilt furniture, and, to a large extent, of the personal domestic servant. And they conclude that we as independent practitioners of medicine are the next vanishing American. There is no denying that the last 36 years have witnessed radical changes in the nature of medical practice. Obstetrics has changed from an almost completely domestic to an almost completely hospital affair. I doubt that there are many in this audience who were born in a hospital, or whose children were born at home. No longer do most doctors spend most of their time making house calls. Specialty medical practice has become so widespread and so widely accepted that no longer does a patient have a family doctor but rather a doctor for each system. Is there then any validity to the prediction of the demise of the independent medical practitioner? My answer is "It all depends-!" On whom? Largely on you and me. Despite the increased efficiency of modern methods and modern medical practice, human nature has not changed. In recently reported work at the Johns Hopkins University School of Medicine, Pavlov's work has been extended to show that conditioned reflexes produce not only physical but emotional responses. The investigator is quoted as saying, "Doctors have long known that it takes more than the right drug to make a patient get better-the presence of the physician himself is important." One who is sick or in pain, or who even thinks he is sick. is no different from his grandfather in that he has the same need for the reassuring presence of one who is personally interested in him as a person, because he has been conditioned from past experience to expect understanding and help from his doctor. The one thing that the private practitioner has to offer his patients that they cannot obtain in assembly line medical dispensaries and clinics, the one thing that cannot be mass-produced and delivered neatly and attractively prepackaged is personal interest, service by one who is interested not only in a disease process but in a person.

It seems to me that in recent years for one reason or another the practice of medicine has become more impersonal. For the first time there is animal experimental evidence to prove something which all of us have known for many years from personal experience: that we as doctors, interested in our patients, have a positive contribution to make to their recovery which transcends mere prescription writing. If we ever lose this aspect of our practice, if the time ever comes when we fail to condition our patients to expect from us not only help but interest and understanding, we will have lost our reason for being. There is no doubt that the vast majority of doctors has a very personal interest in their patients, but sometimes the patient does not know it. The sort of thing that suggests to the patient that the doctor really does not care is so commonplace as hardly to justify mention: The aseptic isolation of the doctor from his patients by his office staff, failure to provide a substitute when out of town, the nine to five disease, failure to take care of people who are acutely ill or injured. All these things and many more exert an influence on the

patients' attitudes toward their doctors. So long as our patients feel that our "first consideration is the welfare of the patient," as stated in our Code of Ethics, we need not fear for the future of medicine. Nor will we need public relations experts to "interpret" us to the public. Our own Dr. Edward R. Annis has shown us what one man can do in re-creating the image of the doctor as the intelligent, dedicated public servant. There is no doubt in my mind that the preservation of the heritage of the service ideal handed to us by our less well equipped predecessors depends more than ever before on the existence of a personal relationship between patient and doctor. Each of us has the responsibility of letting our patients know that service is our business and that the patient is the doctor's reason for being. As we approach another great milestone in history, as the practice of remedial medicine gives way and the age of definitive medicine begins, let us not preside at the deathbed of the medical philosopher while we await the birth of the medical scientist. The future is ours as it has never been before. Is there any validity to the prediction that the private practice of medicine is doomed? Well, gentlemen, it all depends on you and me.

515 South Orange Avenue.

Volume 50 of The Journal, which begins with this issue, will end with the December, 1963, issue, allowing only six instead of the usual 12 numbers. The House of Delegates in session at the Annual Meeting approved the resolution, originating within the Hillsborough County Medical Association, which directed that each volume begin with the calendar year in order to correspond with the other activities of the Florida Medical Association. — T.M.

Medical Care of the Aged The Positive Approach

SAMUEL M. DAY, M.D. JACKSONVILLE

Change is inevitable and must never be opposed for its own sake. This is the space age. It immediately follows the atomic age. Throughout both we might say we have had the medical age. In our lifetime we have witnessed progress in science, in space, in medicine that has overshadowed all that has gone before. It is ironical that this progress is directly responsible for one of our country's greatest current problems—that of the method of payment for medical care, particularly for the older people, whose number has been increased markedly by that very medical care. In the last 20 years, almost as many lives have been saved by good medical care as in all the rest of history. Today the death rate is down to 9.3 per 1,000, the lowest in history. This means 3,945,429 people did not die in the last 20 years because of new medical knowledge, new drugs and new techniques now available to every doctor.

Realizing this progress, our great people rejected the direct socialization of medicine in the defeat of the Wagner-Murray medical bill many years ago. Since then, efforts have been made consistently to divide and conquer. Now, the socializers have narrowed down to the care of our senior citizens. No one is more cognizant of the serious plight of some of these citizens than is the medical profession and no one has worked harder to solve their problems. We must take care, however, lest we permit an emotional issue to cost us our freedom. By our freedom, we do not mean that of the medical profession alone, but that of every citizen of our country, because when the freedom of one group is endangered, that of all others is likewise jeopardized.

The Positive Approach

To take the positive approach we need only to review what is already being done when we consider the problem of medical care of our people, particularly our aged. It has been correctly said that at no time in history has the average American had the ability to pay for medical care that he has at present, and at no time has he been able to buy care of such excellent quality. In addition to the lowered mortality, there is quicker recovery from diseases. It was not many years ago that the average patient with pneumonia remained seriously ill for a matter of weeks, and 202 patients of each 100,000 did not survive. In the average case of appendicitis the patient was hospitalized for two weeks or more, and 30 of each 100,000 patients died. Today, because of modern drugs these patients are out of the hospital in a few days if indeed they require hospitalization. They are back at work much quicker than they would have been 30 years ago. An overall lowering of the cost of medical care results for many people who are ill with serious diseases today. Yet, because of the fact that some of the cost is high for a short period of time, they lose sight of how much the care is worth. Only six patients with pneumonia and only two patients subjected to appendectomy die in each 100,000. The value of our present methods of care should be emphasized repeatedly. Too, one gets more for his money; in 1933, a visit to the doctor cost the average American four hours and 48 minutes in time worked; today, it costs only two hours and three minutes. Less than half—vet how much is it worth?

When we consider the medical care expense in relation to personal income through the last 30 odd years, we find that in 1929 medical care consumed a little more than 4 per cent of the overall personal income in the family. In 1960, medical care took a little more than 6 per cent. Variations over the course of these years are shown in figure 1, but there has been no wider variation than 2 per cent.

When we look at the 1961 dollar, we find that housing takes the greatest bite, 27 cents; food takes 22 cents, clothing 10 cents, travel 12 cents, miscellaneous 12 cents, tobacco and alcohol 5 cents, recreation 6 cents and health only 6 cents. When we consider the health care of our old folks, we find that we are talking about a very small segment of the average dollar. Actually, there are about 17 million old folks, and we are talking about approximately two to two and one-half million of this number who are sick during the year;

President-Elect. Florida Medical Association.

Presented before the Fifth Annual Conference of County Medical Society Presidents and Secretaries, Jacksonville, January 12, 1963. Printed by request.

so we are talking about a very thin line which is invisible in the chart of the 1961 dollar (fig. 2). Even though the health of our senior citizens is important, we must not let an item such as this be blown completely out of perspective.

Medicine, also insurance and our other allies have not been asleep. It was not many years ago that Blue Cross was started by the hospitals and Blue Shield was formed by physicians although it was said that such insurance was impossible on a voluntary basis. All are familiar with the phenomenal success of both and of the cooperative effort made by commercial insurance companies to offer similar insurance. Today, approximately three fourths of our population is covered by some form of hospitalization and health insurance. Over 135 million people have hospitalization insurance, 120 odd million have surgical care insurance, and approximately 100 million have medical care coverage (fig. 3). The bottom line of the chart illustrates a very rapidly growing insurance, as rapidly growing as any in our history. Major medical care began in 1952 and by 1961 was covering approximately 35 million of our population. The over-all coverage given by such insurance assures a person that he will be covered in catastrophic illnesses. Approximately 60 per cent of the aged are now covered by some form of voluntary health insurance. Many insurance companies are making policies available to the aged at reasonable rates. And the aged, as well as the remainder of the population, are demonstrating their acceptance by their participation in these insurance plans.

Who Pays?

Looking at another positive side of what we have now, we examine the payments made for medical care. The 1962 total medical care expenditure was approximately 26 billion dollars. Just who is making these payments today? As shown in figure 4, last year over six billion dollars was paid by health insurance - private voluntary health insurance. Approximately four and onehalf billion dollars was paid by the federal government. In this breakdown approximately 600 million of this amount was paid by Old Age Assistance in the form of payments to old folks. Approximately 200 million of it was for Medical Aid to the Aged payments, which is also for the care of our old people. Another billion and a little more went to the Department of Health, Education, and Welfare, almost another billion to the Veterans Administration, and approximately 600 million to the Department of Defense. Another

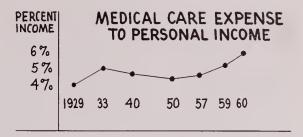


Figure 1



Figure 2

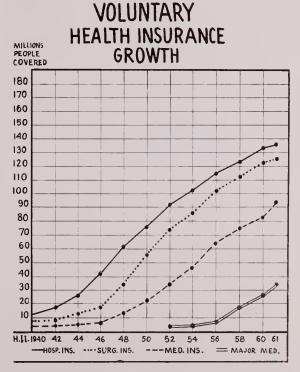
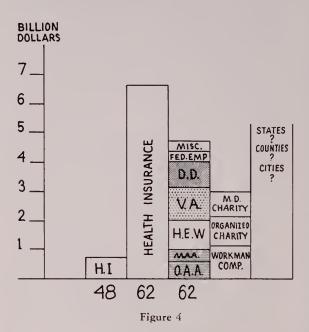


Figure 3

MEDICAL CARE PAYMENTS



FLORIDA VENDOR CARE EXPENDITURES FOR THE INDIGENT

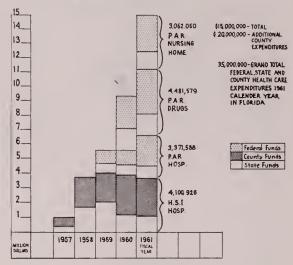


Figure 5

200 to 300 million went to the federal employees and that much again to the miscellaneous group of federal government payments.

Workmen's Compensation, through the form of insurance regulated on a state level, paid for more than a billion dollars in care to injured employees during the course of the year. This sum is in addition to the many educational advantages, safety measures and other benefits which have been made possible through Workmen's Compensation. Charitable organizations, the organized charity of our country, contributed more than a billion dollars toward the care of our needy sick. It is noteworthy that medical doctors of our nation contributed more than 650 million dollars in charity services to patients throughout the year. It is significant that in Florida our doctors contributed more on an individual basis than did the doctors of other states. Our general practitioners rank the highest in the nation, \$4,762 each, and our specialists are second with \$5,078 each.

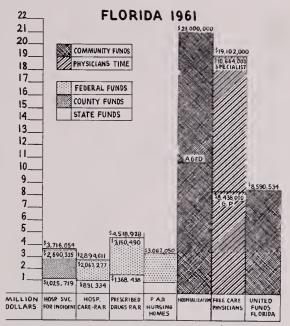
In addition to these contributions, the states. the counties and the cities make tremendous contributions to the medical care payments of the needy people of our nation, an appreciable percentage of whom are over 65 years of age. An exact breakdown on how much they contributed for this particular purpose was not available. If Florida is a reasonable example, these payments total considerably more than those of the federal government. Insurance benefits paid 65.9 per cent of all private hospital bills during the year and 31.9 per cent of all doctors' bills. Previous statistics emphasize that government, insurance and charity are already taking care of the major catastrophic illnesses of our day. Naturally, individuals are still paying considerable sums for office visits, home visits, emergency calls and the like, but these expenses can usually be borne by the individual without hardship, and insurance and government should help on major items that might pauperize an individual or family.

When Governor Collins was elected to his first term as governor, the Florida Medical Association requested that he appoint a citizens committee to study the care of the indigent in the state of Florida. This committee, the Citizens Medical Committee on Indigent Hospitalization, was appointed and was headed by Dr. H. Phillip Hampton, who served with distinction, along with the other members of the committee, and has spearheaded this work in our organization. The committee made a thorough study and made certain recommendations, many of which were accepted by the legislature in 1956, and a sum of \$500,000 was appropriated for a matching fund for the State of Florida. This matching fund was set up so that each county participated on a voluntary basis, contributing a minimum of 50 cents per capita to the fund. The state matched each 50 cents contributed. In 1957, this fund amounted to almost a

million dollars. In 1958, it amounted to almost four million dollars, and at that time the Florida Medical Association again asked Governor Collins to appoint a committee to study the medical care problem in our state, and the Citizens Committee on Health, headed by Dr. Edward R. Annis, was appointed and performed valuable services. Among other recommendations it was suggested that the state participate in a federal matching program for the care of Public Assistance Recipients. This program includes Old Age Assistance, Aid to Dependent Children, and Aid to the Blind and Permanently Disabled. Approximately 70,000 of the 660,000 old folks in Florida were under this program. The legislature again accepted the recommendations, and this portion of federal assistance went into effect, bringing a contribution of approximately 1.2 million federal dollars to the state in 1959. The growing significance of the state fund with its matching federal monies in the care of the indigent of Florida since that time is illustrated in figure 5.

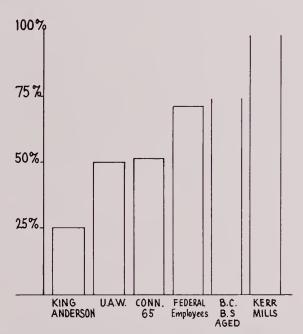
Figure 6 gives a breakdown on the use of these monies in 1961. Hospitalization of the indigent required \$3,716,054, approximately two thirds of which was contributed by the counties and one third by the state. The hospitalization of Public Assistance Recipients required \$2,894,611, approximately two thirds of which was contributed by the federal government and one third by the state. The drugs for Public Assistance Recipients, most of which were for the aged, amounted to \$4,518,928, approximately three fourths of which was contributed by the federal government and the remainder by the state. Nursing home services for Public Assistance Recipients totaled \$3,062,-050, two thirds of which were federal funds. The major share of the cost of the care of the indigent in our state is borne by the counties. Twenty-one million dollars was required for the hospitalization of the indigent in Florida counties in 1961. Approximately half of this was used for the care of the aged indigent. Another contribution of note is that of physicians in free time, which amounted to a total of \$19,102,000, almost as much as the counties contributed for indigent hospitalization. United Funds in Florida also recorded total donations of \$8,590,534 during the year.

These programs combine to assure our citizens that not a person in Florida need go without proper medical care when it is necessary and when it is requested. If doctors and hospitals do not



1961 Total Federal Medical Health Appropriations \$4.4 Billion

Figure 6



PERCENT OF AVERAGE ANNUAL MEDICAL EXPENSE COVERED

Figure 7

know of such care being needed, then it cannot be rendered.

Since several plans have been effected to extend coverage of our old folks, let us look at the

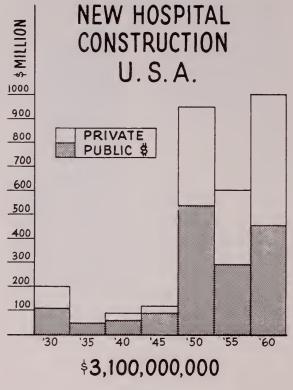


Figure 8

extent of coverage assured by some of these plans. Figure 7 illustrates the percentage of average annual medical expenses covered. The proposed King-Anderson legislation covers less than any of them, since it covers only hospitalization for 90 days (after \$9 deductible daily for 10 days), nursing home care (on transfer from a hospital) for 180 days and home nursing care for 240 days. It omits physicians' services, drugs and other major items of health care.

On the other hand, several plans already in effect pay considerably more of the total costs of medical care, as illustrated. The United Auto Workers' and the Connecticut 65 plans pay approximately 50 per cent of costs. The Federal Employees program is said to cover 65 per cent of costs. The new Blue Shield Aged Contract placed on the market only last October has had insufficient time for experience rating, but with its service agreements in many states it should cover 75 per cent or more. Last and most significant is the Kerr-Mills program which has almost complete care available for those who need it. Legislative proposals already introduced attempt to eliminate any inadequacies. The redeeming feature of the Kerr-Mills Bill is that it can be tailored by a state to meet its particular needs,

and administration is made on a state and local level—not by a federal bureaucracy. It is ironical that the Kerr-Mills Law would have to be used to cover needs made necessary by inadequacies of the King-Anderson Bill if the latter were passed by the Congress.

The 1963 session of the Florida Legislature implemented the Kerr-Mills program of Medical Assistance for the Aged with an appropriation for the biennium (1963-1964 — 1964-1965) for \$3,-250,000. This amount combined with 61 per cent federal funds (\$4,881,646) totals \$8,131,646 for hospitalization and visiting nurse services for those aged in Florida who may be medically indigent.

With regard to new hospital construction, our great country has constructed more hospital beds since World War II than all the rest of the world combined. During this same period, Britain with its socialized program had constructed only one 30 bed hospital until 1958, when a larger program was mandatory because of dire straits of existing hospitals. Looking more closely at the total hospital construction since 1930, we find it was in 1950 that our hospitals really began to be built, and in 1955 and in 1960 more beds were built than through the other years, 1930 to 1950 (fig. 8). Half or more of these beds were built by private enterprise, by private contributions rather than by public funds. It is of interest, too, that 71 per cent of patients are in government-owned hospitals in our country already, even though 67 per cent of all hospitals are privately owned. These figures further emphasize the fact that hospitalization is available for those who need it in our country. Many of the patients in the federal hospitals and state hospitals are there for long term care such as the patients with mental illnesses and tuberculosis, the cost of whose care would break the average family. The Veterans Hospitals continue to care for an ever increasing percentage of our population, many of whom are not there for service-connected illnesses.

For and Against

It has been said that medicine is always against everything. Nothing could be further from the truth. Medicine has been active, and in a constructive way, much of the time. The American Medical Association's Washington office analyzed over 700 bills in 1961 which might have had some relation to medicine and the health of the people of the country. Regarding these measures, doctors from the American Medical Association testified

approximately 40 times. In 26 instances the testimony was favorable to the bills proposed. On six occasions information only was presented. Only four bills were opposed actively. One of these four was the King-Anderson Bill, which had to be opposed vigorously. Once the first skirmish is lost, the battle is lost with a bill such as that, because it violates principles of freedom in our country.

Other Positive Programs

In addition to this legislative effort, organized medicine has made many other constructive efforts in recent years. There has been a constant campaign against unreasonably high fees charged by some doctors and against unavailability of physicians in time of need. This has been manifested by the setting up of grievance committees, or mediation committees in county and state medical societies, which will consider any complaint or charge against a doctor by a patient or the patient's family. The complaint will receive honest sincere consideration, and the person will receive an answer to his complaints. Some doctors have been censored and a few have been expelled from the medical associations because of complaints made to this group. Most complaints have been found to be due to minor irritations which could have been avoided easily by frank discussion between doctor and patient. The American Medical Association has gone on record requesting its members to lower fees for those aged who have difficulty in meeting their medical payments.

Emergency call services have been established by local medical societies to assure physicians' services in an emergency.

Physician placement services are offered by the national and state medical associations to aid physicians in finding places to practice where they are needed.

Surely the great contributions of the American Medical Association to the medical schools since 1910 are well known to all members of the profession. Through education, annual inspections, and adequate standards, the quality of medical schools was upgraded in our country until all schools are now grade A. All substandard schools have been closed or improved. The American College of Surgeons was active for many, many years in the grading of hospitals and improving the standards of these institutions throughout the country. The American College of Surgeons later joined with the American Medical Association, the American Hospital Association and the Canadian Medical Association to form the Joint Commission on Accreditation of Hospitals, which carries on the fine work initiated by the American College of Surgeons. American medicine has made available health advice which provides information on illnesses so that when they strike, one can be better prepared to recognize their presence and the need for the physician's services.

Hospital Utilization Committees are being established by state and county medical societies to assure the availability of hospital beds for the truly sick.

Tax aids for the ill have been requested through the Congress. Some have been granted. Continued work on the part of the aged has been fostered by doctors of medicine. These and many other positive programs have been carried out and are being continued by medicine in America.

415 Medical Arts Building.

Attendance at 89th Annual Meeting Florida Medical Association

Registration for the Annual Meeting held at Hollywood May 16-19 reached a total of 2,055 for the four days, Thursday through Sunday. Of the total, there were 1,111 physicians, 473 members of the Woman's Auxiliary, 258 scientific and technical exhibitors, and 213 other guests.

Proceedings

Eighty-Ninth Annual Meeting

Florida Medical Association Hollywood, May 16-19, 1963

First House of Delegates

The House of Delegates of the Florida Medical Association convened at 9:30 a.m. on Thursday, May 16, 1963 in the Convention Hall of the Hotel Diplomat, Hollywood, Florida, with Dr. Eugene G. Peek Jr., Speaker of the House, pre-

The invocation was delivered by the Reverend Amos L. Boren, Pastor of the Hollywood Hills Methodist Church, Hollywood.

The Speaker announced the membership of the Credentials Committee: Dr. John P. Ferrell, Chairman, Dr. Louis C. Murray and Dr. Thomas M. Irwin.

The Chairman of the Credentials Committee reported that a quorum of the delegates had been registered and moved that they be seated.

Motion seconded and carried unanimously.

Delegates

ALACHUA—Allen Y. DeLaney, William F. Enneking, Walter E. Murphree, Peter F. Regan III, Gerold L. Schiebler.

BAY-Charles H. Daffin, A. Ralph Monaco.

BREVARD—Jack T. Bechtel, Theodore J. Kaminski, Allen E. Kuester, Joseph C. Von Thron.

BROWARD-Curtis D. Benton Jr., Miles J. Bielek, Robert J. Brennan, Russell B. Carson, Leonard A. Erdman, Frederick W. Fisher, Anthony C. Galluccio, Walter J. Glenn Jr., David J. Lehman Jr., John H. Mickley, Lees M. Schadel Jr., W. Dotson Wells, Scottie J. Wilson.

CHARLOTTE—(Absent—Carl N. Reilly)

CLAY-William A. Mulford.

COLLIER—William J. Bailey. COLUMBIA—Harry S. Howell.

COLUMBIA—Harry S. Howell.

DADE—Julius Alexander, William G. Aten, Thomas J. Baker, Clinton L. Border Jr., Richard C. Clay, Jack Q. Cleveland, Milton M. Coplan, Ralph E. Cross, Robert F. Dickey, Richard M. Fleming, Joseph R. Galluccio, Harry Horwich, Paul S. Jarrett, Christian Keedy, David Kirsh, John B. Liebler, Donald F. Marion, Samuel W. Page Jr., Edwin P. Preston, Edward W. St. Mary, Walter W. Sackett Jr., Ralph S. Sappenfield, William A. Shaver, Clifford C. Snyder, William M. Straight, Charles F. Tate Jr., Nelson Zivitz—(Absent—Morris H. Blau, Rufus K. Broadaway, O. Whitmore Burtner, Chester Cassel, John G. Ches-O. Whitmore Burtner, Chester Cassel, John G. Ches-

ney, Edward W. Cullipher, DeWitt C. Daughtry, Victor D. Dembrow, L. Washington Dowlen, M. Eugene Flipse, Maurice M. Greenfield, Morton M. Halpern, John V. Handwerker Jr., James J. Hutson, Thomas W. Hutson Jr., Joseph T. Jana Jr., Banning G. Lary, Alfred G. Levin, Harold Rand, George W. Robertson III, Harold C. Spear).

DESOTO-HARDEE-GLADES-Gordon H. McSwain. DUVAL-Samuel J. Alford Jr., Robert J. Brown, Charles H. Burke, Hugh A. Carithers, Thomas S. Edwards, A. Judson Graves, Gordon H. Ira, Thomas M. Irwin, Edward Jelks, Joseph J. Lowenthal, A. Mackenzie Manson, Thad Moseley, Harry W. Reinstine Jr., Donald P. White Jr., Ashbel C. Williams.

ESCAMBIA—Gerard H. Hilbert, Alpheus T. Kennedy, Labor M. Backerd W. William C. Parine Ser. William M. Carlon M. Backerd W. Live C. Parine Ser. William M. Carlon M. Carlon M. Backerd W. Live C. Parine Ser. William M. Carlon M. Backerd W. Live C. Parine Ser. William M. Carlon M. Backerd W. Live C. Parine Ser. William M. Carlon M. Backerd W. Live C. Parine Ser. William M. Carlon M. Backerd W. Live C. Parine Ser. William M. Carlon M. Backerd W. Live C. Parine Ser. William M. Carlon M. Carlon M. Backerd W. Live C. Parine Ser. William M. Carlon M. Backerd

John M. Packard, Walter C. Payne Sr., William M. C.

Wilhoit.

FRANKLIN-GULF—John W. Hendrix. GADSDEN-LIBERTY—John M. Griffin. HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Ernest R. Bourkard, Herschel G. Cole, Thomas W. Dorr, Irving M. Essrig, Richard S. Hodes, Eugene B. Maxwell, David R. Murphey Jr., Robert H. Owrey, James N. Patterson, Madison R. Pope, Marshall E. Smith, James A. Winslow Jr. INDIAN RIVER—(Absent—Erasmus B. Hardee Sr.)

JACKSON-CALHOUN—James T. Cook. LAKE—Frederick C. Andrews, C. McK. Tyre.

LEE-HENDRY—Fred D. Bartleson, James L. Bradley. LEON-WAKULLA-JEFFERSON—Nelson H. Kraeft, George S. Palmer, Stuart C. Smith, Robert N. Webster.

MADISON—Thomas G. Bouland Jr.
MANATEE—Irving E. Hall Jr., Joseph F. P. Newhall Jr.
MARION—Robert L. Gibson, Henry L. Harrell.

MONROE—(Absent—Ralph Herz).

MONROE—(Absent—Rauph Herzy,
NASSAU—Bradford C. White.

ORANGE—Louis P. Brady, Chas. J. Collins, Norman F.
Coulter, Robert W. Curry, Harry H. Ferran, Truett H.
Frazier, Louis C. Murray, Charles R. Sias, W. Dean
Steward, Miles W. Thomley, Robert L. Tolle.

PALM BEACH—Willard F. Ande, William McC. Byrd, Clarence L. Brumback, James F. Cooney, Russell D. D. Hoover, Lawrence R. Leviton, Philip O. Lichtblau, Samuel A. Manalan, Nicholas S. Petkas, William H.

PASCO-HERNANDO-CITRUS—James W. Basinger.
PINELLAS—Clyde O. Anderson, Charles E. Aucremann,
Charles K. Donegan, Ira C. Evans, John P. Ferrell,
Earl R. Fox, Douglas W. Hood, William H. Keeler
III, Francis H. Langley, Jack A. MaCris, William
G. Mason, Henry E. Smoak Jr., Walter H. Winchester, Rowland E. Wood.

POLK—Clarence L. Anderson, Paul E. Coury, John E. Daughtrey, Marion W. Hester, Charles Larsen Jr., Willard E. Manry Jr.
PUTNAM—Fairfax E. Montague.

ST. JOHNS-Reddin Britt.

ST. LUCIE-OKEECHOBEE-MARTIN-John M. Gun-

solus, Howard C. McDermid. SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Melvin M. Simmons, Milliard P. White.

SEMINOLE—Charles L. Park Jr.
SUWANNEE - HAMILTON - LAFAYETTE—(Absent— Hugo F. Sotolongo.)

TAYLOR-John A. Dyal Jr.

VOLUSIA—James J. Cunningham, Gerald L. Ehringer, William H. Eyster Jr., Richard C. Hartsfield, Robert L. Stevenson

WALTON-OKALOOSA-SANTA ROSA-Maurice Cohen,

Frederick F. Crews.
WASHINGTON-HOLMES—(Absent—Walter H. Shehee) COUNCIL ON SPECIALTY MEDICINE — Jack H. Bowen, Fred A. Butler, Emmet F. Ferguson, David W. Goddard, Samuel G. Hibbs, Ivan Isaacs, V. Marklin Johnson, Wendell J. Newcomb, Leo M. Wachtel, Arthur J. Wallace. (Absent-James D. Beeson, J. K. David Jr., Bernard L. N. Morgan, Thomas E. Scott John H. Webb Jr.)

OFFICERS AND EX-OFFICIO MEMBERS - Jere W. Annis, Reuben B. Chrisman Jr., Edward L. Čole Jr., Samuel M. Day, Burns A. Dobbins Jr., Franklin J. Evans, S. Carnes Harvard, Francis T. Holland, Meredith Mallory, Eugene G. Peek Jr., Warren W. Quillian,

Robert E. Zellner.

The Secretary, Dr. Samuel M. Day, read corrections to the minutes of the Eighty-Eighth Annual Meeting, published in the July 1962 Journal. In the report of the Council on Allied Professions and Vocations, page 38, second column, items (7) and (8) are corrected to read:

(7) That hospital services for chiropodists (podiatrists) as defined in Chapter 461, Section 461.01, Florida Statutes, shall be under the supervision and responsibility of a physician or surgeon member of the medical staff of the hospital.

Dr. Francis H. Langley, of Pinellas, moved that the minutes as amended be approved. Motion was seconded and carried.

The Speaker then introduced the officers of the Association: Dr. Franklin J. Evans, Vice Speaker; Dr. Robert E. Zellner, President; Dr. Warren W. Quillian, President-Elect; Dr. Edward L. Cole Jr., Vice President; Dr. Samuel M. Day, Secretary-Treasurer and Mr. W. Harold Parham, Executive

The Speaker then remarked:

Remarks of the Speaker

EUGENE G. PEEK, JR.

The Speaker and Vice Speaker welcome you to the Eighty-Ninth Annual Meeting of the Florida Medical Association and the Third Annual Meeting of the House of Delegates of the Florida Medical Association held under the new Charter and By-Laws.

The Speaker would like to urge upon all Delegates and all members of the Association that it is not only their privilege but their duty to appear before the Reference Committees to give their points of view concerning any resolutions in which they are interested. With this in mind, the Speaker strongly recommends a most careful study of the resolutions which appear in your Handbook or packet prior to appearing before the Reference Committees. I would like to call to your attention that all

resolutions received too late to be published in the Handbook but received in time to be duplicated in the home office will be in your Delegate's packet.

The Speaker and Vice Speaker wish to assure you that each will preside according to the principles of recognized parliamentary procedure. The Speaker urges each of you, if at any time you disagree with any rule or decision of the Speaker, please to feel free to question the decision or to appeal the decision so that it can be immediately put to the vote of the House. In view of the extensive medical and legal background of your distinguished Vice Speaker, I have asked him to act as Parliamentarian of this session.

It is the duty of the presiding officer to expedite the business of the House as much as possible; however, not to such a degree as to curtail the opportunity of any member to rise and be recognized at any time to discuss any matter before the House, and he urges all Delegates to object at any time to any ruling which the Speaker makes. The Speaker requests that the Delegates address all remarks to the Speaker so that there cannot possibly arise any conflicts of personalities between discussants. It is well to remember the words of the first Speaker of the House of Delegates of the Florida Medical Association, Dr. Joseph S. Stewart, when he stated, "We are here to discuss resolutions and not to discuss personalities."

The Speaker called attention to the information on Business Travel Accident Insurance which was included in the Delegates' packets.

Several distinguished guests were introduced by the Speaker: Mrs. Edward W. Ludwig, President, and Mrs. Abbott Y. Wilcox Jr., President-Elect, Woman's Auxiliary to the Florida Medical Association, and the fraternal delegate from Puerto Rico, Dr. Enrique A. Vincens of Ponce.

Dr. Peek said: "The Speaker takes the prerogative of making a personal introduction of guests. While Cooper is in his seventeenth flight around this world, we have two guests, one a past president of the Woman's Auxiliary now making her seventy-sixth orbit through life and the other a past president of the Florida Medical Association now making his eighty-second orbit through life. It is my pleasure to present to you my mother and father, Dr. and Mrs. Peek."

He then introduced The Honorable Delbridge L. Gibbs, President of the Florida Bar, and member of the law firm of Marks, Gray, Yates, Conroy and Gibbs, which is the legal counsel for the Florida Medical Association, who addressed the House:

"Dr. Peek, Dr. Zellner, Distinguished Guests, Ladies and Members of the Florida Medical Association: I am something like that bird dog that a lawyer friend of mine in Tallahassee has. He's a very fine male bird dog. The other day, inadvertently, he entered him in an all female bird dog show. I asked him if his dog had taken any honors, and he said, 'Oh heck, no, but he sure was delighted to be there.'

'So I am delighted to be here to bring you the greetings and warm felicitations of the more than 8,400 lawyers of Florida. Just two weeks ago your president-elect, Dr. Quillian, whose brother here in Hollywood is one of the fine leaders of the Florida Bar, addressed the thirteenth annual convention of the Florida Bar. At that time the weather was rather poor—in fact it was raining hard. As a result, we had almost as good an attendance at some of our meetings as you have here, which is remarkable for lawyers. Being a representative not only of the medical profession, but also of Dade County, the doctor was obliged to refer to the weather as a 'gully-washer' and a 'toad-strangler.' Now that is Georgia talk, friends, for 'there's no golf today.' I am glad to see that you doctors have a better influence on the weather than we lawyers had

had.

"It is a particular pleasure for me to be here today, because our law firm, and particularly my indefatigable partner, Harry Gray, has for many, many years enjoyed the privilege of serving the medical profession of Florida as its attorney, working with your very hard-working executive director, Harold Parham, and all of the many outstanding and dedicated presidents and officers of your association. It has been a great privilege and, indeed, an

inspiration.

'My being here represents a bit more than a happy social contact and exchange of pleasantries between two of the three great learned professions, organized medicine and the organized bar of Florida. It is a further evidence, in my opinion, of the increasingly close and productive liaison and indeed working relationship that your great association and the Florida Bar have had and will continue to enjoy and promote. There are many areas in which we can and do make common cause. For instance, the Bar was happy to study, to consider and to lend its active support to an important part of your legislative program currently being handled in Tallahassee. Specifically, I refer to the so-called Good Samaritan Bill and also the Privileged Communications Bill. I would be less than candid if I did not admit there are points of contact which, principally because of misunderstandings on both sides of the fence, sometimes become sources of friction between us. Yet men of good will in both professions have always been able to resolve these minor differences that have arisen, and I pledge to you again that the Florida Bar will give its complete, unqualified, yes, eager cooperation in solving any problem which may affect our two great professions to the end that we both will serve what we intend to serve-the best interests of

the public as a whole.

"The lawyers of Florida salute you! Have a good convention! And thank you very much for inviting me

here."

The Speaker introduced Mr. Harry T. Gray, the Association's legal counsel.

Dr. Peek: "It now gives me great pleasure on behalf of the Board of Governors to present the third annual award for outstanding community service by a physician which is made available by the A. H. Robins Company. Details of the recipient's many accomplishments and activities upon which this selection was made by the Board of Governors will be passed out to you as they are too numerous for the Speaker to enumerate. Our recipient this year is Jere W. Annis, of Lakeland, whom you all know. Jere, will you come forward?"

Dr. Zellner: "This is something that Jere did not know about, nor did anyone else. We are not reading his many accomplishments because we have to be through with this meeting by 11 o'clock. All of you know that if we started telling you about Jere Annis, we would be here all day. I would like also for you to know that this selection was made not on what Jere has done for Medicine,

but for community service. Jere, it is with a great deal of pleasure that I present this to you."

The recipient of the 1963 Community Service Award of the A. H. Robins Company is Dr. Jere Wright Annis of Lakeland. The award is presented annually to honor a member of the Florida Medical Association who is particularly interested in community affairs and renders distinguished public service. Dr. Annis was chosen for this honor by the Board of Governors of the Association from nominees submitted by the component county medical societies.

The son of a physician, Dr. Annis was born in Minneapolis, Minn., on April 30, 1909. After attending Phillips Academy, Andover, Mass., and Dartmouth College, Hanover, N. H., he completed his academic schooling at Cornell College, Mount Vernon, Iowa, where he received the Bachelor of Arts degree in 1930. For his professional training he returned to Minneapolis to enter the University of Minnesota Medical School and four years later was awarded the degree of Doctor of Medicine. He served an internship at the Minneapolis General Hospital and then spent three years as a fellow in internal medicine at the Mayo Clinic. In 1938 he entered the private practice of medicine in Lakeland and has continued in active practice there except for five years spent in military service during World War II. He has been associated with the Watson Clinic in that city since its inception at the close of the war, and largely under his leadership it has

become an outstanding medical facility.

Dr. Annis has long been active in the Lakeland Chamber of Commerce, serving as vice president in 1957 and holding other offices including the chairmanship of the National Affairs Committee. Interested in city government, he has served as a member of the Citizens Committee for Recall and as a candidate for Lakeland City Commissioner. For years a director of Boys' Club of Lakeland, Inc., he is currently president of that organization. He has participated in Parent-Teacher Association activities, and served as a trustee of the Polk County Guidance Center, a member of the Community Welfare Council of West Polk County, chairman of the Health and Safety Committee of the district Boy Scouts organization, advisor to the Lakeland Chapter of the American Red Cross and medical director of the Polk County unit of Florida Civil Defense. A thirty-second degree Scottish Rite Mason and a member of the American Legion, he is also a member of the local Rotary Club, Elks Club and Yacht Club. He holds membership in the Lakeland and Winter Haven Rifle clubs and in the National Rifle Association and the West Coast Pistol League.

A member of the staff of the new Lakeland General Hospital, Dr. Annis assisted in its establishment and in setting up its internship training program. He is a former secretary and trustee and a past president of the Polk County Medical Association. For many years he has represented this society in the House of Delegates of the Florida Medical Association. Other county and area posts include membership on the Polk County Hospital Board, director of the Polk County Heart Council and chairman of its Speakers Bureau, consulting staff member of Bartow Memorial Hospital, member of the medical staff of South Florida Baptist Hospital in Plant City, advisor to the Polk County Licensed Practical Nurses Association of Florida and member and past president of the Advisory Board, Winter Haven Licensed Practical Nurses School.

Representing Congressional District Seven, Dr. Annis has been especially active on the State Welfare Board and was recently reappointed for a two year term. He has served as Vice President of Blue Shield of Florida, Inc., and as a director of the Florida Rehabilitation Association. A member of the Florida Medical Committee for Better Government, he also holds membership on the Medical Advisory Committee to the University of Florida College of Medicine, the Medical Advisory Committee to the Vocational Rehabilitation Service, and the Florida Health Awards Committee of the Florida Citrus Commission. In addition, he is a Visiting Instructor to the University of Miami School of Medicine, a director of

the Florida Heart Association serving on its Finance Committee and Constitution Committee, and chairman of the Long Range Planning Committee of the Florida Society of Internal Medicine. In 1958, Dr. Annis was President of the Florida Medical Association. He has rendered distinguished service to the Association through the years

in many important posts.

At the national as well as the state level, Dr. Annis has an impressive record of activities. His service includes membership on the Economic Security Committee of the Chamber of Commerce of the United States and on its Subcommittee on Health Care Benefits, participation as a panelist for the Conference on National Health, Welfare and Pension Plans, membership on the Board of Trustees of the American Association of Medical Clinics, and membership in the Florida Assembly on "Atoms for Power" Seminar. He was reappointed this year to the chairmanship of the Committee on Legislation of the American Society of Internal Medicine. Currently, Dr. Annis represents the Florida Medical Association in the House of Delegates of the American Medical Association and last year became a member of the Speakers Bureau of that

This versatile physician finds time to wield a facile pen. He has made notable contributions to literature, not only on medical and scientific subjects but also on public problems and in the fields of poetry, drama and the novel. His first published novel, "And These Shall See," written in collaboration with Mary Ann Ballard of Homestead, has been released recently for sale by Dor-

rance and Company of Philadelphia.

The Speaker: "This is the first time I have ever seen Jere speechless."

Dr. Peek: "The next speaker, whose accomplishments are also too numerous to tell-your President, Bob Zellner."

The Delegates gave Dr. Zellner a standing ovation as he came to the podium to speak.

(Complete text of the President's Address begins on page 19.)

The Speaker introduced another distinguished visitor, Mr. C. Joseph Stetler, Director, Legal and Socio-Economic Division of the American Medical Association.

Dr. Peek read the personnel of Reference Committees as follows:

I. HEALTH AND EDUCATION Nelson Zivitz, Chairman Alpheus T. Kennedy

John M. Butcher Charles R. Sias Henry L. Harrell Meredith Mallory, Advisory

Francis T. Holland, Advisory

II. PUBLIC POLICY James T. Cook, Chairman Marshall E. Smith Curtis D. Benton Jr. Irving E. Hall Jr.

Reuben B. Chrisman Jr., Advisory III. FINANCE AND ADMINISTRATION W. Dean Steward, Chairman George S. Palmer Gordon H. McSwain

L. Washington Dowlen

Joseph C. Von Thron
Jere W. Annis, Advisory
IV. LEGISLATION AND MISCELLANEOUS James F. Cooney, Chairman Fred A. Butler

Jack Q. Cleveland Ernest R. Bourkard Jack A. MaCris Burns A. Dobbins Ir., Advisory

The various meeting rooms for the Reference Committees and the time for each meeting were announced by the Speaker.

The Speaker called attention to two beautiful bouquets of red roses, one at each end of the speaker's table which had been placed there by Dr. Clifford Snyder, Chairman of the Committee on Archives, in memory of the members who died during the last year. In honor of these members, the assembly stood in silence for one minute.

The Speaker reminded the Delegates that all of them should have read the Handbook before coming to the meeting and for that reason, he would not read the reports and resolutions, but that they would be handled by the Reference Committees as shown in the Handbook. He then asked for supplemental reports and resolutions.

Dr. A. Mackenzie Manson, of Duval, presented an amendment to Resolution 63-5 on Vocational Rehabilitation, which the Speaker referred to Reference Committee No. IV.

Dr. W. Dean Steward, of Orange, presented a resolution on the Advisory Committee to Blue Shield, which was assigned to Reference Committee No. IV and given the number 63-21.

Dr. Charles F. Tate Jr., of Dade, presented a resolution by the Dade County Medical Association on Smoking. This was given the number 63-19 and was assigned to Reference Committee No. II.

At this time, Dr. Ferrell gave a supplemental report of the Credentials Committee, stating that 187 Delegates had been registered. All county societies except three were represented.

Dr. A. Mackenzie Manson, of Jacksonville, presented a resolution, To Discourage Cultist Recognition in Organized Medicine. This was assigned to Reference Committee No. III and given the number 63-23.

The Speaker announced that the paragraph regarding Blue Shield at the top of page 33 of the Handbook would be referred to Reference Committee No. IV rather than to No. III.

Dr. John M. Gunsolus, of St. Lucie-Okeechobee-Martin, presented a resolution on prescriptions, which was assigned to Reference Committee No. II and given the number 63-20.

Dr. Walter W. Sackett Jr., of Dade, presented as an individual a resolution on the "Liberty

Amendment," which was given the number 63-24 and assigned to Reference Committee IV.

Dr. Sackett also stated that the Dade County Medical Association had passed a resolution regarding Hospital Area-Wide Planning, which did not appear in the Handbook. It was being dictated over the telephone at that time, but did not arrive in time to be read to the House. This was, however, presented to the Reference Committee No. 1 as a memorandum for information, but not for action.

Dr. Madison R. Pope, of Hillsborough, presented a resolution on The Journal. This was given number 63-22 and referred to Reference Committee No. I.

Dr. William M. Straight, of Dade, asked if it would be possible to have the actual Liberty Amendment duplicated to pass out to the Delegates as background information. The Speaker promised that he would try to have it mimeographed.

Dr. Zellner asked the unanimous consent of the House to consider Resolution 63-2 on Reference Committees by the Board of Governors so that the procedure outlined in the resolution could be utilized for this Annual Meeting. He moved that the rules be suspended so that a vote could be taken on this resolution at the First House of Delegates.

Motion was seconded and passed unanimously. He then moved that Resolution 63-2 as printed in the Handbook be adopted.

Motion was seconded and carried.

Resolution 63-2

Reference Committees Board of Governors

Whereas, the Reference Committees of the House of Delegates of the Florida Medical Association, established by the By-Laws, exist for the benefit of the membership of the Association, to express openly and freely their opinions regarding policies under consideration by the House of Delegates; and

Whereas, Each individual member of the Association should have the opportunity, as he desires, to express an opinion freely, without concern of the effect upon those other than members of the Association; therefore he it

RESOLVED, That the policy of the Florida Medical Association shall be to restrict those in attendance at any meeting of any Reference Committee of the House of Delegates to members of the Florida Medical Association, other doctors of medicine who are guests of the Association, members of the Association staff required to assist the Committee, and only such other individuals who shall be invited by the officers of the Association or the Reference Committee itself.

The Speaker announced that the President's Guest Speaker, Senator Roman Hruska, would be heard at 11 a.m. on Friday; the Woman's Auxiliary luncheon would be held on Friday, May 17, 12:30 p.m., and the Florida Medical Committee for Better Government would meet at 5:00 p.m. today.

The Speaker then read an announcement that in response to a questonnaire mailed out following the last Annual Meeting, the Florida Association of Industrial and Railway Surgeons was disbanded on December 31, 1962. After its books were audited and all outstanding bills were paid, the remaining assets in the amount of \$4,158.16 were given to the Florida Medical Foundation to establish a permanent trust, to be known as the Florida Association of Industrial and Railway Surgeons' Medical Student Loan Fund. This trust fund will be administered by the Foundation under the same rules and regulations it uses for its own medical student loan fund, but will perpetuate the name and memory of the Florida Association of Industrial and Railway Surgeons.

He also announced that the annual Blue Shield meeting would convene at 11:00 a.m.

The House of Delegates recessed at 10:40 a.m. to reconvene on Sunday, May 19, at 9:30 a.m.

Second House Of Delegates

The House of Delegates reconvened at 9:30 a.m. on Sunday, May 19, 1963 in the Convention Hall of the Hotel Diplomat, Hollywood, Florida, with Dr. Eugene G. Peek Jr., Speaker of the House, presiding.

Dr. John P. Ferrell, Chairman of the Credentials Committee, reported that 184 Delegates were officially seated, constituting a quorum.

Delegates

ALACHUA—Allen Y. DeLaney, William F. Enneking, Walter E. Murphree, Peter F. Regan III, Gerold L. Schiebler.

BAY—Charles H. Daffin, A. Ralph Monaco.

BREVARD—Jack T. Bechtel, Theodore J. Kaminski, Allen E. Kuester, Joseph C. Von Thron.

BROWARD—Curtis D. Benton Jr., Miles J. Bielek, Robert J. Brennan, Russell B. Carson, Leonard A. Erdman, Frederick W. Fisher, Anthony C. Galluccio, Walter J. Glenn Jr., David J. Lehman Jr., John H. Mickley.

Lees M. Schadel Jr., W. Dotson Wells, Scottie J. Wilson.

CHARLOTTE-Carl N. Reilly. CLAY-William A. Mulford.

COLLIER—(Absent—William J. Bailey)

COLUMBIA-Harry W. Howell.

DADE—Julius Alexander, William G. Aten, Thomas J. Baker, George S. Baldry, Clinton L. Border Jr., Richard C. Clay, Jack Q. Cleve'and, Milton M. Coplan, Ralph E. Cross, DeWitt C. Daughtry, Victor D. Dembrow, Richard C. Dever, Robert F. Dickey, L. Washington Dowlen, Richard M. Fleming, Joseph R. Galluccio, Kermit H. Gates, Harry Horwich, Paul S. Jarrett, Harold S. Kaufman, Christian Keedy, David Kirsh, John B. Liebler, Joseph Lomax, Donald F. Marion, John D. Milton, Samuel W. Page Jr., Walter W. Sackett Jr., Ralph S. Sappenfield, William A. Shaver, Clifford C. Snyder, William M. Straight, Charles F. Tate Jr., Corren P. Youmans, Nelson Zivitz (Absent—Rufus K. Broadaway, Chester Cassel, Edward W. Cullipher, Morton M. Halpern, James J. Hutson, Thomas W. Hutson Jr., Banning G. Lary, Alfred G. Levin, Edwin P. Preston, Harold Rand, George W. Robertson III, Edward W. St. Mary, Harold C. Spear)

DESOTO-HARDEE-GLADES-Gordon H. McSwain. DUVAL-Samuel J. Alford Jr., Robert J. Brown, Charles H. Burke, Hugh A. Carithers, Thomas S. Edwards, A. Judson Graves, Gordon H. Ira, Thomas M. Irwin. Edward Jelks, Joseph J. Lowenthal, A. Mackenzie Manson, Thad Moseley, Harry W. Reinstine Jr., Donald P. White Jr., Ashbel C. Williams.

ESCAMBIA-Gerard H. Hilbert, Alpheus T. Kennedy, John M. Packard, Walter C. Payne Sr., William M.

C. Wilhoit.

FRANKLIN-GULF—John W. Hendrix. GADSDEN-LIBERTY—(Absent—John M. Griffin).

HIGHLANDS-Donald C. Hartwell.

HILLSBOROUGH-Ernest R. Bourkard, Thomas W. Dorr, Irving M. Essrig, Richard S. Hodes, Eugene B. Maxwell, James N. Patterson, Madison R. Pope, Marshall E. Smith, James A. Winslow Jr. (Absent-II rschel G. Cole, David R. Murphy Jr., Robert II. Owrey).
INDIAN RIVER—Erasmus B. Hardee Sr.

JACKSON-CALHOUN-James T. Cook

LAKE—Frederick C. Andrews, C. McK. Tyre. LEE-HENDRY—Fred D. Bartleson, James L. Brad'ey. LEON-WAKULLA-JEFFERSON—Nelson H. Krac George S. Palmer, Stuart C. Smith, Robert N. Webster. MADISON—(Absent—Thomas G. Bouland Jr.

MANATEE—Irving E. Hall Jr., Joseph F. P. Newhall Jr. MARION-Henry L. Harrell (.1bsen!-Robert L. Gib-

MONROE-Ralph Herz.

NASSAU—(Absent—Bradford C. White)

ORANGE-Louis P. Brady, Chas. J. Collins, Norman F. Coulter, Robert W. Curry, Harry H. Ferran, Truett H. Frazier, Louis C. Murray, Charles R. Sias, W. Dean Steward, Miles W. Thomley, Robert L. Tolle.

PALM BEACH—William McC. Byrd, Clarence L. Brum-

back, James F. Cooney, Russell D. D. Hoover, Lawrence R. Leviton, Philip O. Lichtb'au, Samuel A. Mana'an, Nicholas S. Petkas, William H. Proctor (Absent— Willard F. Ande).

PASCO-HERNANDO-CITRUS-James W. Basinger. PASCO-HERNANDO-CITRUS—James W. Basinger.
PINELLAS—Clyde O. Anderson, Charles E. Aucremann,
Charles K. Donegan, Ira C. Evans, John P. Ferrell,
Douglas W. Hood, William H. Keeler III, Francis H.
Langley, Jack A. MaCris, William G. Mason, Henry
E. Smoak Jr., Walter H. Winchester, Rowland E.
Wood (Absent—Earl R. Fox).

POLK-Clarence L. Anderson, Paul E. Coury, John E. Daughtrey, Marion W. Hester, Willard E. Manry Jr. (Absent-Charles Larsen Jr.).

PUTNAM-Fairfax E. Montague.

ST. JOHNS—Reddin Britt. ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Howard C. McDermid.

SARASOTA—John M. Butcher, Samuel E. Kaplan, Melvin M. Simmons, Millard P. White (Absent—Karl R. Rolls).

SEMINOLE—Charles L. Park Jr.

SUWANNEE-HAMILTON-LAFAYETTE — (Absent— Hugo F. Sotolongo).

TAYLOR-John A. Dyal Jr.

VOLUSIA—Gerald L. Ehringer, William H. Eyster Jr., Richard C. Hartsfield, Robert L. Stevenson (Absent— James J. Cunningham). WALTON-OKALOOSA-SANTA ROSA—Maurice Cohen,

Frederick F. Crews.
WASHINGTON-HOLMES—(Absent—Walter H. Shehee).
COUNCIL ON SPECIALTY MEDICINE — Jack H.
Bowen, Fred A. Butler, J. K. David Jr., Emmet F. Ferguson, David W. Goddard, Ivan Isaacs, Wendell J. Newcomb, Leo M. Wachtel, Arthur J. Wallace (Absent—James D. Beeson, Samuel G. Hibbs, V. Marklin Johnson, Bernard L. N. Morgan, Thomas E. Scott Jr., John H. Webb Jr.).
OFFICERS AND EX-OFFICIO MEMBERS—Jere W.

Annis, Reuben B. Chrisman Jr., Edward L. Cole Jr., Samuel M. Day, Burns A. Dobbins Jr., Franklin J. Evans, S. Carnes Harvard, Francis T. Holland. Meredith Mallory, Eugene G. Peek Jr., Warren W. Quillian, Robert E. Zellner.

The Speaker read a telegram addressed to Dr. Zellner from Dr. Robert B. Quattlebaum, fraternal delegate from the Medical Association of Georgia, expressing his best wishes for a successful meeting and his regret that for personal and professional reasons he was unable to attend. He also read a telegram from Joseph A. Lane, President, Medical Society of the State of New York, expressing best wishes and congratulations to Dr. Zellner and Dr. Quillian.

Dr. Peek recognized visitors from allied professions: Mrs. Edith Jones, of Jacksonville, representative of the Medical Assistants Association; Mrs. Anna Rundell, Coral Gables, Florida Division, American Society of Medical Technologists; Mr. Dan H. Davis, President, Florida State Pharmaceutical Association; Robert A. Giudice, D.S.C., President, Florida Podiatry Association; M. B. Teigland, D.V.M., President, Florida State Veterinary Medical Association.

The Speaker called on Dr. Shaler Richardson to stand and complimented him on his 42 years of consecutive attendance at Florida Medical Association Annual Meetings.

Dr. Edward R. Annis, President-Elect of the American Medical Association, was introduced and was asked to introduce his guest, The Honorable Mallory Horne, Speaker, Florida House of Representatives. The House gave Dr. Annis a standing ovation.

Speaker Horne opened his talk by chiding the medical profession for "stirring briefly between a sleep and a sleep" in political matters. He discussed the delicate balance of power in the Constitution of the United States and the threat to this balance by a change in the philosophy of the Supreme Court and by preemption of power by the federal government. He further stated that in these times it may be necessary to grant additional powers to the federal government, but if so, the people of the United States should participate in this change in the same fashion in which they created the delicate balance in the beginning.

With this in mind, another sleeping organization was roused to consider the matter-the Council of State Governments. First, it was asked to consider whether there should be any degree of autonomy by states, or whether they should be merely subdivisions of the federal government. Second, to propose changes in Article V of the Constitution, so that the Congress would be required to consider amendments proposed by two thirds of the states. Third, to consider the establishment of a "Court of the Union" to be composed of the elected Chief Justices of each state, who may come into action when five states, none of which share a common boundary, feel that the expression of power by the Supreme Court exceeds the intended grant of power.

He concluded by calling attention to the "pie in the sky" medical scholarship programs pending in the Congress which would educate doctors who would be more amenable to the socialistic programs of a paternalistic government.

Dr. Zellner then presented to Dr. Peter F. Regan, of the University of Florida College of Medicine, representing Dean George T. Harrell, a check from the American Medical Association Educational Research Foundation in the amount of \$5,752.82, which is a contribution free of all restrictions as to use, and because the American Medical Association pays the expense of solicitation and transmittal, every contributed dollar goes to the school. A similar check, in the amount of \$5,943.82, was presented to Dean Hayden C. Nicholson, of the University of Miami School of Medicine, and Dr. Zellner welcomed him to his first Florida Medical Association Annual Meeting.

Dr. Zellner introduced Mr. Victor Hruska, Vice President of The Prudential Life Insurance Company of America, and Vice Chairman of the Health Insurance Council of Florida, the representative of Commercial Health Insurance working with the Association's Committee, and a brother of the Guest Speaker, Senator Roman Hruska.

He then introduced his Guest Speaker, The Honorable Roman Hruska, United States Senator from Nebraska. Senator Hruska had been scheduled to speak on Friday, but had been detained in Washington to vote on an important farm bill.

Senator Hruska presented a stirring and challenging address. He expressed thankfulness for the leaders in Medicine who thus far have been successful in the long fight against socialized medicine. He cited the many examples of federal solutions to problems, including the problem of medical care for the aged, and stated that believing the King-Anderson approach is the proper one represents superficial thinking. He called attention to improvements in health care since the original "Socialized Medicine Bill" in 1947-an increased number of health insurance policies, improved pension plans, and the plan in Florida for medical care of the aged, and stated that legislators have not kept up to date with these things that have been happening in the medical field.

The Senator spoke of the Drug Act of 1962, advising the Delegates that this is a good bill; however, there were already vast reservoirs of power in the Food and Drug Administration which will not be utilized, and had they been utilized and enforced, would have made passage of the drug bill unnecessary. He expressed hope that this law would be allowed to function and not be fastened down with "more harness than horse."

Senator Hruska spoke of two philosophies of government. The first was extension of government to all activities—causing enlargement of government in size, scope and cost, removing power from the communities, counties and states. Citing the correlation of his address with the address of the Honorable Mallory Horne, he then presented the second philosophy—that of a delicate balance of the distribution of power, with that power not specifically designated for a certain body to be reserved for the people of the United States.

In conclusion, he urged his audience to bear constantly in mind that they must have interests beyond their profession, and to interest themselves in the affairs of the nation, because "Not with politicians, not with Presidents, not with office-seekers, but with you is the question, 'Shall the union and shall the liberties of this country be preserved to all future generations?'"

Senator Hruska was given a standing ovation in appreciation for his thought-provoking presentation.

The Speaker requested Dr. Nelson Zivitz. Chairman of Reference Committee No. I, to come to the rostrum and present the report of his Committee.

REPORT OF REFERENCE COMMITTEE NO. 1

Health and Education

Dr. Nelson Zivitz: "Mr. President, Mr. Speaker, and Members of the House of Delegates: Your Reference Committee on Health and Education has carefully considered each of the items referred to it, and desires to present the following report. The Reference Committee's recommendation on each item will be submitted separately, and I respectively suggest that each item be acted upon before going to the next.

"The report of the Council on Medical Education and Hospitals is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Medical Education and Hospitals

EDWARD W. CULLIPHER, Chairman

Council:

There has been no meeting of the full Council during the past year. Correspondence indicates there have been no pressing problems presented to the Council for consideration. Continuing interest has been directed toward establishment of a liaison committee between the Florida Medical Association and the Florida Hospital Association. The purpose of such a committee would be to consider matters of mutual concern and interest.

Disposition of resolutions referred to the Council is as follows:

Resolution 62-35 — Cost of Medical Care by the Broward County Medical Association was referred to and is currently a matter of consideration by the newly activated Commission on Cost of Medical Care in Florida.

Resolution 62-7 — Accreditation of Hospitals — Pathology Departments by the Pinellas County Medical Society remains as an item for future consideration of the full Council.

The resolution from the Dade County Medical Association regarding reimbursement of the University of Miami School of Medicine and Jackson Memorial Hospital for indigent patient care which was referred to the Council by the Board of Governors on January 12, 1963, is approved with re-wording of the final paragraph, so that it reads as follows:

"BE IT FURTHER RESOLVED that the University of Miami School of Medicine be included on an equal basis with the University of Florida College of Medicine from the standpoint of admitting these patients for teaching purposes and that Jackson Memorial Hospital be on an equal basis from the standpoint of monies received from the State for admission of such indigent patients."

Committees:

Committee on Physician Placement.—The Committee on Physician Placement held two official meetings, May 9,

1962, and February 2, 1963, and carried out other business by correspondence and telephone. During the year, the Committee has continued its dual function of 1) establishing and revising policy for the Association's physician placement service, which is administered by the Executive Office, and 2) serving, along with the deans of the state's two medical schools, as advisory committee to the State Medical Student Scholarship Program.

In the Committee's opinion, the physician placement service, for which policies must be continually evaluated and revised where necessary, is fulfilling a highly worthwhile and needed service to both the profession and the public.

In its capacity as advisory committee to the state scholarship program, the Committee has recommended to the State Board of Health that the statute governing this program be amended by the 1963 regular session of the legislature in a manner which will accomplish the following purposes:

 Authorize the awards of scholarships up to \$2,000 per year with a maximum of \$8,000 per four years.

Provide for a period of compensatory practice for nine months for each \$2,000 granted and utilized.

 Permit a scholarship recipient either to serve the required period of compensatory practice or to repay the scholarship with interest at 6 per cent per annum, compounded semiannually.

With the exception of the period of compensatory practice, these recommendations are identical to those submitted by the Committee in 1962 and approved by the State Board of Health.

Recommendations of Council for House of Delegates' approval:

That the Florida Medical Association seek the implementation of the Dade County Resolution in the Florida legislature

That further study of the Committee on Hospitals be deferred until other studies now going on can be further evaluated.

That, since it is recognized the problem of desirable interns and residents is unsolved in many hospitals in our state, continued study of medical schools and liaison with them be maintained.

"The report of the Scientific Council is approved as printed in the Handbook, with commendation to the Chairman and his Committee for the quality of the scientific program.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Scientific Council

THAD MOSELEY, Chairman

Council:

Through careful planning and economies which have not detracted from the value or appearance of The Journa!, it has been possible to publish 12 issues since the last Annual Meeting with revenue from advertising. In this period, 58,715 copies have been published and circulation has been increased by more than 200 copies each month despite efforts to hold it to a minimum. A total of 1,034

pages has been printed. Included in this total were 626 pages of advertising and 247 pages of scientific articles. The remainder has been miscellaneous matter, such as editorials and Clinical Comment. Costs of publication totaled \$30,528.14 and revenue amounted to \$33,514.47, an excess of \$2,986.33 over costs.

The members of the Committee on Scientific Work met in May to decide upon a tentative program for the 1963 Annual Meeting and in December to make final plans and select the papers to be presented. Frequent discussion among members has been maintained in order that smaller problems might be solved promptly and necessary changes in program plans might be agreed upon. The program this year consists of a combination of instate and out-of-state speakers of university caliber. Featured will be a problem case panel, an obstetric-gynecologic symposium and a motion picture program. Some 28 scientific exhibits have been approved. A survey questionnaire will be distributed at each session for remarks concerning the various presentations. It is hoped that the results will prove useful in planning future programs.

The Committee on Postgraduate Education met in May in order that the function of the Committee might be better understood, and again in January for a discussion of the problem of postgraduate education at the University of Florida College of Medicine. Recommendations concerning the problem were presented to the Board of Governors of the Florida Medical Association and were approved. Further action is being taken by the Board. The Committee has reviewed and endorsed more than 25 different courses and seminars, and has furnished information on them to The Journal for publication.

It is the belief of the Committee that a pamphlet should be published three or four times each year listing all courses and seminars and as many data as possible concerning the programs and speakers. It would be mailed to all members and could be self-supporting through advertising. The pamphlet might well assist in promoting increased attendance at some of the excellent programs which might go unnoticed otherwise. It is further believed that a better coordinated statewide postgraduate program could be attained by closer communication between the Committee and a similar committee within the two medical schools and possibly the Florida Institute for Continuing University Studies.

The Committee on Research has continued to consider all applications for grants and to give information to the Florida Medical Foundation concerning them. Five applications have been received; five have been reviewed; two are pending, and three have been finalized.

The report of the Council on Specialty Medicine was approved with the exception of its last paragraph. The Reference Committee offered three paragraphs as a substitute for this one paragraph. When this was read to the House of Delegates, Dr. James N. Patterson, of Hillsborough, moved to delete the first paragraph of the Committee's recommendation. Dr. Patterson's motion carried. The recommendation then read:

"3. Committee on Pathology.—Concern is expressed about the unwarranted utilization of the State Board of Health laboratories by those who are able to pay for laboratory services.

"It is recommended that advertising by lay clinical laboratories in official medical journals and in technical exhibits should be discontinued."

Dr. Zivitz: "Mr. Speaker, I move the adoption of this portion of the report as amended."

Council on Specialty Medicine

EMMET F. FERGUSON JR., Chairman

Council:

The Council on Specialty Medicine held three meetings during the Association's administrative year 1962-63. The Council is composed of representatives of 15 medical specialties, and these representatives are ex-officio members of the House of Delegates. The Council has a Subcommittee on Specialty Groups which consists of a representative for each of the 22 specialty groups officially recognized by the Association. The Florida Association of Industrial and Railway Surgeons, formerly represented on the Subcommittee, was disbanded in December 1962. In January 1963 the Board of Governors, on recommendation of the Council, granted official recognition to the Florida Society of Physical Medicine and Rehabilitation.

Members of the Council served as consultants to the Committee on Fee Schedules in preparation of the 1962 Florida Medical Association Relative Value Studies. Following detailed study and untiring work of these two groups, led by Henry J. Babers Jr., the 1962 Florida Medical Association Relative Value Studies was published

in October 1962.

The Council on Specialty Medicine serves in a liaison capacity in working with specialty groups. Specialty group members should bring their problems before the Council for discussion and mediation rather than take individual action. In effect, the Council on Specialty Medicine acts as a forum for members of the Association.

At the request of the Council, individual specialty groups polled their members to ascertain the 10 most common hospital and the 10 most common office procedures of each specialty, with the average fee for each procedure. At the time this report is written, 10 of the groups have submitted this information. The Council is of the opinion that such a poll, conducted annually, may be one of the means utilized to keep the Relative Value Studies current.

Council members are preparing brief articles concerning their specialties for publication in The Journal, These articles are to be entitled "What Is Your Specialty?" and will provide not only background information, but the current status and functions of each specialty.

The Council is of the opinion that if the 1962 Relative Value Studies is accepted by the Florida Industrial Commission, it would be desirable to establish county review committees and a state review committee to review any Workmen's Compensation claims which may present problems. The Council thought that this might be handled in a manner similar to the present Medicare Mediation Committees.

Following careful study and deliberation, the Council made the following recommendations:

- That the Committee on Fee Schedules make available to the Florida Industrial Commission a medical advisory review committee as soon as possible to review Workmen's Compensation claims in accordance with a "no fee" published schedule of procedures and code numbers.
- 2. That approval be given to the following resolution: "Whereas, The Relative Value Studies has been considered in detail by the Florida Medical Association and has been subsequently adopted by the House of Delegates; and

Whereas, Numerous other medical groups have found the relative value concept a satisfactory guide for arriving at a fair fee for service rendered; and

Whereas, The Committee on Fee Schedules, Council on Specialty Medicine and Board of Governors approved and have made available the 1962 Relative Value Studies; therefore be it

RESOLVED, That in compliance with past directives of the House of Delegates the Florida Medical Association continue to seek implementation of the relative value principle by adoption of the 1962 Relative Value

Studies and also urge its adoption by the following groups

1. Medicare

2. Blue Cross-Blue Shield

- Crippled Children's Commission
- Council for the Blind Veterans Administration

6. Vocational Rehabilitation 7. Florida Industrial Commission, and

8. Other voluntary third party programs of medical care, including commercial insurance carriers.'

3. That county medical societies be requested to encourage establishment of medical audit, insurance review, and utilization committees in hospitals in their communities.

It is believed that the Council on Specialty Medicine offers an excellent forum for the multifaceted problems of medicine and its specialties and that all members of the Association should communicate such problems to their specialty group for consideration of the Council as a whole. Unity is our strong point, and it is the primary purpose of the Council to nurture this unity, and at the same time to approve any recommendation of any specialty group which benefits medicine as a whole, and to solve the problems of individual groups by the concerted effort of all the specialty groups. It is thought that the group should meet three or four times yearly, and that all representatives should be present if at all possible. It is suggested that each specialty group transmit to the Chairman any items to be placed on the agenda and that this be a continuing process.

The Council was gratified to receive expressions of commendation for the manner in which it is handling problems which confront it from several of its component specialty groups, i.e., orthopedics, urology, plastic sur-

gery and general surgery.

In addition to the Council recommendations, several Committees made individual recommendations:

1. Committee on Internal Medicine. — That regular meetings be held three or four times yearly to deal with current problems and attempt to "brain trust" for the future of medicine in Florida.

2. Committee on Ophthalmology and Otolaryngology.-That further studies be carried on in regard to: (a) Noise in Industry; (b) Hearing Aids for Adults; and

(c) Testing of the Pre-School Child.

3. Committee on Pathology.—Concern is expressed about the unwarranted utilization of the State Board of Health laboratories by those who are able to pay for laboratory services.

It is recommended that advertising by lay clinical laboratories in official medical journals and in tech-

nical exhibits should be discontinued.

"Resolutions 63-4, 63-12, and the Memorandum from the Dade County Medical Association regarding Area-Wide Hospital Planning were considered together and the Committee recommends the adoption of Resolution 63-4 with the following changes:

"Paragraph 3 of the Resolved be changed to read:

"To assure that representatives of such agencies be primarily derived from organized medicine, professional and business leaders of the communities, dedicated to the preservation of free enterprise.

"Paragraph 4 be changed to read:

"To inform the Florida Hospital Association that the Florida Medical Association regards compulsory areawide planning in some of its facets as an encroachment upon the private practice of medicine in hospitals.

"Paragraph 5 be deleted."

"A new paragraph to be added to read:

"And be it further resolved, that the Florida Medical Association recommend to the American Medical Association that careful study be given this report, particularly as far as its socialistic and bureaucratic implications are involved; and that the Florida Medical Association recommend to the American Medical Association that appropriate steps be taken to counteract these implications.

"Mr. Speaker, I move the adoption of this resolution as amended."

No discussion; no objection, motion carried.

Resolution 63-4

Area-Wide Hospital Planning Lake County Medical Society

Whereas, The report of the Joint Committee of the American Hospital Association and the U.S. Public Health Service on area-wide planning for Hospitals and related Health Service is suggesting that there be local planning agencies for each region having a substantial hospital planning problem; and

Whereas, This will cause an increasing dominance of the hospital building picture by government and state agencies through altered Hill-Burton approach; and

Whereas, The ultimate plan visualizes hospital plant at some distance from the patient's small local community; therefore, be it

RESOLVED, That the Florida Medical Association study the area-wide planning programs for hospitals in its committee with the following objectives in mind:

1. To limit each such area to regions within the state

as is commensurate with the problem involved;
2. To alert the County Societies to fight enabling legislation which would convert this from a voluntary to a compulsory system;

3. To assure that representatives of such agencies be primarily derived from organized medicine, professional and business leaders of the communities, dedicated to the

preservation of free enterprise;

4. To inform the Florida Hospital Association that the Florida Medical Association regards compulsory areawide planning in some of its facets as an encroachment upon the private practice of medicine in hospitals, and be it further

RESOLVED, That the Florida Medical Association recommend to the American Medical Association that careful study be given this report, particularly as far as its socialistic and bureaucratic implications are involved; and that the Florida Medical Association recommend to the American Medical Association that appropriate steps be taken to counteract these implications.

"Resolution 63-14 is approved with the addition of another paragraph as follows:

"AND BE IT FURTHER RESOLVED, That the House of Delegates recommend to the Governor of Florida that members of the Florida Medical Association be represented on the advisory boards of state hospitals, and that copies of this resolution be forwarded to the Governor of the State of Florida, the Florida Senate and the House of Representatives.

"Mr. Speaker, I move the adoption of this resolution as amended."

No discussion; no objections, motion carried.

Resolution 63-14

Hospital Boards

Board Of Governors

Whereas doctors, as citizens, should take an active

interest in community affairs, and

Whereas hospitals need active support and advice of the members of the medical community and only by having physicians active on governing boards can proper liaison between administration and staff be maintained, and

Whereas Doctors of Medicine possess knowledge that can be valuable to hospital administration; therefore be it

RESOLVED, That the House of Delegates recommend to each county medical society that it actively and aggressively promote membership by members of their respective societies on governing boards of the hospitals within their area, and be it further

RESOLVED, That the House of Delegates recommend to the Governor of Florida that members of the Florida Medical Association be represented on the advisory boards of state hospitals, and that copies of this resolution be forwarded to the Governor of the State of Florida, the Florida Senate and the House of Representatives.

"On Resolution 63-15 the Committee recommends that this resolution be approved with the addition of the following phrase to the first RE-SOLVED, at the top of page 58: 'and implemented in accordance with state laws and ethical principles of the American Medical Association;'

"The Committee recommends the deletion of the second RESOLVED, and the addition of the following paragraph:

"AND BE IT BE FURTHER RESOLVED, That the Florida delegation to the American Medical Association House of Delegates be instructed to present and to support these views at the next meeting of the AMA House of Delegates.

"The statement of the Board of Governors regarding this resolution was considered with the resolution and utilized as information upon which this recommendation is made.

"Mr. Speaker, I move the adoption of this resolution as amended."

No discussion; no objections, motion carried.

Resolution 63-15

Interns and Residents

Board of Governors

Whereas, The source of revenue for payment of salaries of interns and residents will vary with the individual hospital being dependent on charges to patients, endowment, public funds, etc. available to a particular hospital, and

Whereas, That while there are now at least three internships to every two interns, the hospitals paying the lowest salaries more nearly fill their quotas than the higher paying ones, indicating that other considerations than money influence medical school graduates in the selection of their internships, and

Whereas, However praiseworthy the desire to increase the compensation of interns and residents, if the manner in which this is done increases the inroads of hospitals into the private practice of medicine, it will in the long run defeat its purpose, and

Whereas, The American Medical Association has now under study the entire matter of internship and residen-

cy training; therefore, be it

RESOLVED, That the method and adequacy of payment of interns and residents be left to individual hospitals and their medical staffs, and implemented in accordance with state laws and ethical principles of the American Medical Association, and be it further

RESOLVED, That the Florida delegation to the American Medical Association House of De'egates be instructed to present and to support these views at the next meeting of the AMA House of Delegates.

"The Committee recommends adoption of resolution 63-18 on Foreign Physicians with deletions and additions necessary to effect wording as follows:

"Whereas, The Council on Medical Education and Hospitals of the American Medical Association has issued the requirement that 25 per cent of house staffs in approved intern and residency training programs be graduates of medical schools in the United States or Canada; and

"Whereas, this action will increase the difficulties that already exist in adequate staffing of many hospitals; and "Whereas, certain hospitals do not usually consider

foreign physicians in selecting house staff; therefore, be it "RESOLVED, That the American Medical Association be requested to require through its Council on Medical Education and Hospitals that each approved internship and residency program shall have a minimum of 25 per cent foreign trained physicians who meet the requirements of the Educational Certification of Foreign Medical Graduates.

"Mr. Speaker, I move the adoption of this resolution as amended."

Dr. William M. C. Wilhoit, of Escambia: "We feel that this resolution is an unworkable method to defeat that which we do not like now, namely, the requirement that 25 per cent of interns and residents on the house staff be graduates of medical schools of the United States or Canada. We feel it would be preferable to defeat that, rather than try to make another rule to recommend 25 per cent foreign-born. We would recommend that you defeat this resolution."

Dr. James T. Cook, of Jackson-Calhoun: "We have neither residents nor interns in our small hospital. I think people are trying to find a solution with laws and regulations that will be coercion upon medical staffs in hospitals. I think it is entirely beyond the province of the medical association to try to force any hospital to have a certain number of foreign graduates. How far are we going to carry foreign aid anyway? I would strongly urge that this substitute resolution be defeated."

Dr. Richard C. Clay, of Dade: "I speak for my delegation whose members feel unanimously that this resolution should be defeated." Dr. Marshall E. Smith, of Hillsborough, also spoke against this substitute resolution.

Dr. Day: "I want to explain how this resolution came about. It is not entirely without benefit as a positive approach. There are resolutions going before the American Medical Association to try to defeat the 25 per cent rule that is in effect. I believe all of us feel that is an unfair rule. The chances of it being defeated may not be too great because it was just passed at the December meeting. Today's resolution came about because the smaller hospitals around the country, the community hospitals, are required at this time to have the 25 per cent of American graduates in order to have a qualified program. A man who does much thinking along these lines brought up the fact that it would be just as fair, maybe more so, to say that all hospitals should have 25 per cent foreign graduates, the main point being that it would free some of these American graduates who would be tied up in the University hospitals, et cetera, and not available to the community hospitals which are required to have the 25 per cent American graduates. It looks like this will not pass, but certainly it is not without good points on its side."

The motion was defeated.

Dr. Zivitz: "Resolution 63-22, pertaining to volume numbering of The Journal, which was pre-

sented to the First House of Delegates by the Hillsborough County Medical Association, is approved.

"Mr. Speaker, I move the adoption of this resolution."

No discussion; no objections, motion carried.

Resolution 63-22

Volume Numbering of The Journal Hillsborough County Medical Association

WHEREAS, medical researchers expect to find all volumes of medical journals to begin concurrently with the calendar year; therefore, be it

RESOLVED, That the volume numbers of The Journal of the Florida Medical Association be changed so that its volume numbers begin with the January issue instead of the July issue.

"Mr. Speaker, I move the adoption of the entire report as amended."

No discussion; no objections, motion carried.

Dr. Zivitz expressed appreciation to all those who appeared before his Committee and to the members of Reference Committee No. I, Drs. Alpheus T. Kennedy, John M. Butcher, Henry L. Harrell, Charles R. Sias, and the two advisory members, Drs. Meredith Mallory and Francis T. Holland.

Dr. Franklin J. Evans, Vice Speaker, then took the Chair.

REPORT OF REFERENCE COMMITTEE

NO. II

Public Policy

Dr. James T. Cook, Chairman: "Mr. Speaker, and Members of the House of Delegates: The Reference Committee on Public Policy has considered each of the items referred to it and desires to present the following report.

"The Reference Committee considered the report of the Council on Allied Professions and Vocations as printed in the Handbook and makes the following recommendations: The Committee recommends that recommendation No. 3 be deleted and that recommendation No. 4 be amended to read: 'That the Florida Medical Association take particular cognizance of the splendid interest and efforts of the presidents of the various junior colleges and other institutions in their endeavor to establish schools of nursing and thus aid in the alleviation of the critical shortage of nursing personnel.' This Committee also recommends that

recommendation No. 8, page 20 in the Handbook, in view of the fact that this requires a change in the By-Laws, be referred for consideration to the Board of Governors. The Committee commends Dr. Kenaston for his fine work as chairman of the Council on Allied Professions and Vocations.

"Mr. Speaker, I move the adoption of this portion of the report, as amended."

Dr. Day rose to a point of order, and called attention to the fact that the change in the By-Laws had already been recommended by the Board of Governors and was included in the Board of Governors' report.

After some discussion, Dr. Zellner moved to amend: "That the sentence in question be changed to read, 'The Committee takes note that this recommendation has been considered by the Board of Governors and specific recommendations have been made for consideration of the House."

The amendment carried.

The motion, as amended, carried.

Council on Allied Professions and Vocations

THOMAS C. KENASTON SR., Chairman

Council:

The Council met on September 9, 1962, with seven of its 10 members present. This meeting was devoted largely to review and planning of individual Committee programs. Because it was not possible to hold another meeting of the entire Council before the reporting deadline, the majority of the recommendations are Committee recommendations which were not reviewed by the Council. As of this writing, no reports were received from the Committee on Medical Assistants and the Committee on Veterinary Medicine.

In addition to their continuing function of maintaining liaison with the allied groups, a wide variety of activities was carried out by the Committees of the Council. The Committee on Dentistry was instrumental in the recent establishment of a medical liaison committee by the Florida State Dental Society. The Committee on Law has developed a proposed professional code between physicians and attorneys and has participated in medicolegal programs before local medical societies and bar associations. The Committee on Medical Technicians has been working with medical technology groups in formulating a state program of accreditation of medical laboratories.

The Committee on Nursing has represented the Association on the advisory committees to the State Department of Education on Practical Nurse and Health Occupations Education and on Nursing Training in the Public Junior Colleges. This Committee also reviewed proposals and made recommendations for expanded nursing education in the state university system at the request of the Board of Control, advised the Illinois State Medical Society concerning the proposed establishment of the Associate degree program in the junior colleges of that state, suggested to the Florida Nurses Association the creation of a medical liaison committee which subsequently was established, and participated in a meeting with the legislative committee of the state nurses group at their invitation.

The Committee on Pharmacy has held informal meetings with representatives of the Florida State Pharmaceutical Association relative to matters of common interest. The Committee on Podiatry has worked toward standardizing policy statements of different medical groups with regard to podiatry and has met with representatives of the Florida Podiatry Association. The Committee on Physical Therapy has advised the Florida Chapter, American Physical Therapy Association, regarding various specif-

ic problems of concern to that group.

In summary, it may be stated generally that the results of the Council's activities are measured most accurately over an extended period of time. At this point, the Council has not been functioning long enough to draw any valid conclusions. In the whole, the progress observed so far would justify the Council's existence.

Council Recommendations:

- (1) That active liaison committees between county medical and dental societies be established to consider problems of mutual interest not only in the scientific field but in such areas as legislation and civil defense and disaster.
- (2) That, because nursing is the profession closest to medicine and one upon which medicine is particularly dependent, and as such should be its staunchest ally, and because it is unthinkable that great differences should arise or that there would not be complete cooperation and

friendship between the two professions, there be continuing effort to improve liaison with the nursing profession

(3) That the Florida Medical Association take particular cognizance of the splendid interest and efforts of the presidents of the various junior colleges and other institutions in their endeavor to establish schools of nursing and thus aid in the alleviation of the critical shortage of nursing personnel.

(4) That study and discussion of the ethics of physician ownership of pharmacies and pharmaceutical re-

packaging houses be continued.

(5) That the American Medical Association position relative to the hospital formulary system be supported by the Florida Medical Association and that the Florida State Pharmaceutical Association be encouraged to join in this

(6) That an appropriate officer or member of the Florida State Pharmaceutical Association be requested to submit an article to The Journal of the Florida Medical Association on the subject of problems between the physician and pharmacist concerning prescription writing and

(7) That for the purposes of providing improved liaison with each allied group through wider geographic availability and for improved function of committees through delegation of duties, the By-Laws of the Florida Medical Association be amended to provide that Committees of the Council on Allied Professions and Vocations are regular standing committees rather than special standing committees-of-one.

Dr. Cook: "The report of the Council on Voluntary Health Agencies is approved as printed in the Handbook and the Committee commends Dr. Romaine on a job well done.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Voluntary Health Agencies

MASON ROMAINE III. Chairman

Council:

One official meeting of the Council was held on January 19, 1963. The Association's program relative to voluntary health agencies has been an active one and has followed several different paths, all of which, it is hoped, will lead to the same objective: establishment and maintenance of the medical profession's responsibility and leadership in the public interest with respect to the voluntary health organization movement.

The programs of the seven statewide voluntary health agencies officially recognized by the Association were reevaluated in early 1963, and no grounds were found for discontinuance of recognition for any individual agency. The agencies currently recognized are the Arthritis and Rheumatism Foundation, Florida Chapter; American Cancer Society, Florida Division; Florida Society for Crippled Children and Adults; Florida Heart Association; Florida Association for Mental Health; National Founda-tion, and Florida Tuberculosis and Health Association. The applications of three other agencies were considered, and official recognition was recommended to the Board of Governors for two agencies.

During the year, the Council has worked with the state voluntary agencies in various direct and indirect ways. The Chairman and the Association staff member assigned to the Council appeared by invitation as speakers on the program of the 1962 Institute for Voluntary Health Agencies held in August at Winter Park. The Council was invited to attend and participate in the planning of the 1963 Institute, to be held in Jacksonville in June. These annual programs are sponsored by the Florida

Institute for Continuing University Studies, in cooperation with the 12 major voluntary agencies. In addition, informal contacts with agency personnel have helped result in the formation of a long-needed coordinating committee between the agencies themselves, which currently is awaiting final approval of each individual agency. For the first time, the executive directors of the seven recognized agencies were invited to meet with the Council. Such a meeting was held January 19, 1963, and the results were gratifying. It was decided to hold similar meetings at least annually.

The Council has been working with the Secretary of State of Florida in implementing an advisory committee for the voluntary health organization registration law, the formation of which was recommended by the House of Delegates in 1962. A representative of the Secretary of State met with the Council at its January meeting. As of this writing, the committee has not as yet been established, but plans are well advanced and final action is expected in the very near future. Such an advisory committee should be of considerable assistance in carrying out the intent of this law. Authorization for the Council to continue its work toward this goal is requested (see recommendation below).

At the request of the American Medical Association Committee on Voluntary Health Agencies, the Chairman and the Association staff member assigned to the Council appeared before the committee on February 5 and 6 in Chicago to describe and answer questions concerning the Florida program. The American Medical Association has been interested in the Florida program as a possible pilot study for other states. The Chairman has been appointed as a member of the American Medical Association Com-

mittee on Voluntary Health Agencies.

With an active and expanding program established on a state level, the Council is now directing increasing attention to local voluntary health agency problems and programs. Before formulating any proposals, and in an attempt to ascertain conditions within the various counties, the Council in March sent out a questionnaire to the county medical societies requesting information with reference to relations and liaison with local voluntary health agencies.

It was recommended to the Board of Governors as provided in the By-Laws that the Florida Society for the Prevention of Blindness and the Florida Council for Retarded Children be granted official recognition by the Association as voluntary health agencies, with the provision that the latter agency secure medical representation either on its state board of directors or by establishing a medical advisory committee, or both, within the near future.

Recommendations of Council for House of Delegates' Approval:

That the Council on Voluntary Health Agencies be authorized to continue the provision of assistance to the Secretary of State of Florida in implementing an advisory committee for the voluntary health organization registration law.

"The Reference Committee considered the report of the Council on Medical Services and its component committees with the following recommendations:

"The Reference Committee recommends that the recommendation of the Committee on Aging be changed to read: 'That homemaker-type services under local support and control be endorsed by the Florida Medical Association as a healthrelated extension of home patient care.'

"Mr. Speaker, I move the adoption of this portion of the report, as amended."

No discussion; no objections, motion carried. "The report of the Committee on Blood is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "The Reference Committee considered the report of the Committee on Child Health and recommended the following amendment: 'Recommendations: That efforts be made to ascertain the number of functional county school health advisory committees and urge the appointment of such committees by those county medical societies not having one.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

"The Reference Committee considered the report of the Committee on Hearing and recommends that paragraph (d), page 24 in the Handbook, be amended to read as follows: 'Consider the Establishment of Communicative Disorder Teams. It is proposed that these would be at the regional centers and would be so designed after the plan of the Cleft Palate Teams to deal with the children with severe communication disorders. It is recommended that such teams be constituted to contain, when reasonably available, an otologist, audiologist, pediatrician, psychologist, pediatric neurologist, plastic surgeon, and other specialists when indicated.' The Reference Committee further recommends that recommendations No. 4 and 5, and the supplemental report of the Council on Medical Services (which you will find in your Delegates' packet) recommending that the Florida Crippled Children's Commission be requested to undertake the care of indigent children with hearing and visual defects, be deleted. Recognizing the need for financial assistance in the definitive care of children with hearing and visual defects, the Committee feels that the proposed method of financing this might not be the best and recommends that the Board of Governors give this careful study and further that the Board of Governors make a thorough study of the Crippled Children's Commission as it affects the private practice of medicine and patient care in Florida.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried. "The Reference Committee considered the report of the Committee on Labor and recommends approval of the report as printed in the Hand-book.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "The Reference Committee considered the report of the Committee on Maternal Health and recommends that recommendation No. 7, page 26 in the Handbook, be amended to read: '...Committee on State Legislation be requested to consider . . .' and that the words 'one or two' be deleted.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried. "The Reference Committee considered the report of the Committee on Mental Health and recommends that recommendation No. 8, page 27, be amended to read: 'That early priority be given....' and after the word children, substitute 'in Florida' for the remainder of the paragraph.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried. "The report of the Committee on Public Health is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "The report of the Committee on Rural Health is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "The report of the Committee on Vision is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "On the recommendations of the Council on Medical Services, the Committee recommends that the second Resolved in recommendation No. 20, appearing on page 29 in the Handbook, be changed to read: 'That the Florida Medical Association, through an appropriate committee, support and encourage existing educational programs designed to influence young people not to start the habit of smoking cigarettes' and that an additional Resolved be added as follows: 'Be it further resolved, that the Florida Delegates to the American Medical Association introduce a similar resolution to the AMA.'

"Mr. Speaker, I move the adoption of this portion of the report, as amended."

Dr. DeWitt C. Daughtry, of Dade: "We, of the Dade County delegation, would like to introduce an amendment to this and I will go into our reasoning. Our resolution which was read by Dr. Tate on Thursday, and received about a two minute ovation, was not in the Handbook originally because we felt we should go through orderly channels, and the Dade County membership passed it unanimously, but we did not have time to get it into the Handbook. I am sorry that I was not able to be at the Reference Committee meeting; unfortunately, I had to be in Denver at another meeting. I agree with the Committee in contracting and combining both the Dade County resolution and the one appearing in the Handbook, but do feel that in the best interest of the resolution, and really to spell out the scientific facts and make this resolution more effective, this should be amended. I would like to state further that it is so very important that this be carried through in the proper form, particularly since it is recommended that it go to the American Medical Association for consideration there. All of the major chest organizations in the entire world have gone on record as approving such a resolution, but a resolution stated a little differently and, I think, a little more meaningful than the one that we are considering at this time—the one that has been moved and seconded and approved by the Reference Committee.

"Therefore, I move that this resolution on smoking and health be amended and adopted to read as follows:

Substitute Resolution for 63-19 Regarding Smoking

"Whereas, the preponderance of evidence indicates that cigarette smoking is strongly implicated in the genesis of lung cancer, chronic bronchitis and emphysema; therefore, be it

fore, be it
"'RESOLVED, That the Florida Medical Association
go on record as advocating the voluntary giving up of
cigarette smoking by those now smoking; and be it further

"'RESOLVED, That the Florida Medical Association through an appropriate committee help develop new, where none exists, and support and encourage existing educational programs designed to influence young people not to start the habit of smoking; and be it further

"'RESOLVED, That the Florida delegates to the American Medical Association introduce a similar resolution to the American Medical Association at the annual meeting, June 1963."

"This was written up in this form rather than taking up a lot of time stating where we changed a few words. There is not much difference, but I think this is a much more effective resolution and I move that this be amended."

The amendment to the motion carried. Motion as amended carried.

Dr. Cook: "I would like to say that our Committee strongly commended Dr. Hester and his Council on Medical Services for their excellent work."

Council on Medical Services

MARION W. HESTER, Chairman

Council:

Official Council meetings were held June 10, 1962, and March 17, 1963, with nine of the 12 members present at each meeting. The former meeting was devoted largely to consideration of Council organizational procedures and reviewing and planning individual Committee programs. At the latter meeting, the activities and annual reports of the Committees were considered in detail and recommendations to the Board of Governors and House of Delegates adopted. As of the date of this report, no reports were received from the following Committees: Blood, Emergency Medical Service, and Indigent Care. Any reports received subsequently from these Committees, therefore, will not have been considered by the Council and consequently are not included as part of this report. In general, several of the Council's Committees have extremely active programs with an increasing volume of activities. The need for one or two Committees is questionable. The remaining Committees either have relatively constant programs of limited degree, or their potential is undeveloped. For purposes of clarity and organization in this report, each Committee's recommendations which were approved and adopted by the Council are shown immediately following the summary of the Committee's activities. Two matters which were acted upon by the Council as a whole are shown as Council recommendations. All recommendations are numbered consecutively.

COMMITTEES:

1. COMMITTEE ON AGING

The Committee continued its program as outlined in the report of last year. Various plans for treatment of the aging in Florida were considered. Discussion was held with regard to plans as practiced in Westchester County, New York, Saint Louis County, Missouri, and Kenosha, Wisconsin. The Committee concluded that the medical care rendered to the aging in Florida is satisfactory and that these other plans would not, at this time, be recommended. Members of the Committee participated in the workshop on home care held in Miami in October 1962. The Committee endorses the expansion of home care programs as an integral part of progressive patient care. The Council on Medical Services approved the motion of the Committee that each county medical society have at least one program during the year on problems of aging.

The Committee expresses its appreciation to Dr. Simon D. Doff of the State Board of Health for his frequent valuable contributions in our discussions during the meetings.

Recommendations:

 That homemaker-type services under local support and control be endorsed by the Florida Medical Association as a health-related extension of home patient care.

2. COMMITTEE ON BLOOD

The Committee has had one of its most active years. At the 1962 meeting of the House of Delegates a motion was carried which instructed the Committee on Blood to cooperate with the Florida Association of Blood Banks in working out a satisfactory solution in respect to a program for Jackson-Calhoun counties. The Committee met with representatives of the Florida Association of Blood

Banks in Orlando on June 9, and fully discussed the problem. Following this representatives of the Florida Association of Blood Banks met with representatives of the counties involved. A satisfactory blood program was agreed upon. To date no further word has been received from the counties involved, and it is assumed that no further problem exists.

Later in the year the Committee was again called upon to assist Central Florida Blood Bank of Orlando and the Brevard County Medical Society in working out a satisfactory solution to a problem which existed at that time. The Brevard County Society was seriously considering the services of the American Red Cross. The Committee on Blood gave whatever assistance it could to the parties concerned. With the cooperation of the Florida Association of Blood Banks again a satisfactory solution was had.

The Committee Chairman wishes to express his thanks to all persons who so willingly cooperated and aided in the arbitration of these matters.

Recommendations:

Continuation of the existing Blood Program of the Florida Association of Blood Banks with the organization continuing its effort to aid the smaller counties and their hospitals in technical education and Blood Program management.

3. COMMITTEE ON CHILD HEALTH

Study was instituted of the existing county school health advisory committees as to how the number can be increased and the quality of the current ones improved. A meeting was held on August 5, 1962, with representatives of the State Board of Health and State Department of Education with counseling largely on matters pertaining to education An outline of these subjects has been presented in another report (Report of Committee on Education Department to Council on Legislation and Public Agencies).

Recommendations:

That efforts be made to ascertain the number of functional county school health advisory committees and urge the appointment of such committees by those county medical societies not having one.

4. COMMITTEE ON EMERGENCY MEDICAL SERVICE

5. COMMITTEE ON HEARING

The Committee on Hearing was established by the House of Delegates in May 1962. On August 20, 1962, members of the Committee attended a joint meeting on hearing problems with national and state public health and education officials at which a suggested program for the Committee was formulated. Later Committee meetings were held December 8, 1962, and February 6, 1963. Each of the Committee members has been assigned responsibilities for various phases of the Committee's functions and activities.

Recommendations:

 That the following proposed state school hearing testing program be approved and that standards and equipment used be established by the Florida Society of Ophthalmology and Otolaryngology.

(a) The Employment of a Full Time Speech and Hearing Consultant as a member of the State Health Department to direct the entire program and act as liaison between the various organizations concerned in the conservation of hearing. This consultant should have a Master's or Doctor's degree in speech and hearing, with advanced certification in either speech or hearing.

(b) Test Personnel. Public health nurses, operating out of the district offices, can execute the initial phase of the hearing testing program. A short, one-to-two-day training program should be held two or three times per year to train them. Such a training program can and will be set up at the University of Florida Teaching Hospital. It is suggested that the job of testing might be limited to a selected few of the public health nurses, rather than attempting to train them all. It is believed that in this manner these nurses will be more familiar with the techniques they are using.

- (c) Audiologic Testing Centers (for information only).

 The University of Florida J. Hillis Miller Health Center, Florida State University, Speech and Hearing Center in Jacksonville, University of Miami, and Tampa General Hospital all have existing personnel and equipment for handling the child with severe communicative disorders. Some of the programs need bolstering for more team effort in handling their cases. The information that these programs are available should be made known to the medical profession and to the State Board of Health and county health departments.
- (d) Consider the Establishment of Communicative Disorder Teams. It is proposed that these would be at the regional centers and would be so designed after the plan of the Cleft Palate Teams to the deal with the children with severe communication disorders. It is recommended that such teams be constituted to contain, when reasonably available, an otologist, audiologist, pediatrician, psychologist, pediatric neurologist, plastic surgeon, and other specialists when indicated.

(e) Administration of Program. It is recommended that this program should be financed and administered by the Florida State Board of Health and that the Committee on Hearing of the Florida Medical Association should act in an advisory capacity.

6. COMMITTEE ON INDIGENT CARE

7. COMMITTEE ON LABOR

The Committee on Labor held two official meetings during the year, on November 11, 1962, and March 2, 1963. The primary purpose of the former meeting was to plan an informal, preliminary dinner session with selected state labor leaders, which was held on March 2. At this latter meeting, exploratory talks were held, as authorized by the House of Delegates in May 1962, toward the establishment of a joint state labor-medical liaison committee. On several other occasions, the Chairman has bad personal contact and correspondence with state labor leaders. In the Committee's opinion, this communication to date has been worth while and further efforts should be pursued.

Recommendations:

6. That authorization be granted for the Florida Medical Association to take the leadership in establishing, and participate jointly as an equal partner in, a continuing state labor-medical liaison committee, the scope of which was enumerated in the 1961-62 annual report of the Committee on Labor, as adopted by the House of Delegates in May 1962.

8. COMMITTEE ON MATERNAL HEALTH

This Committee has retained its three prime objectives—conduct of the Maternal Mortality Survey, advocating the passage of new state laws relating to obstetrics and gynecology, and presentation of the annual Postgraduate Obstetric-Pediatric Seminar.

The Maternal Mortality Survey of 1961, the first conducted in Florida, was completed successfully and reported in The Journal of the Florida Medical Association. Physician cooperation and acceptance were excellent. The 1962 survey is now almost completed. The effectiveness of this and all subsequent surveys is greatly reduced by the inability of the survey committee to write evaluations to the doctors concerned. Until proper protective legislation is found, any such comments can be used as legal evidence against the individual physician.

Four proposed laws, either new or revised, were presented to the Committee on State Legislation. One of

these, creating Privileged Communication, was accepted for introduction into the 1963 legislature. Three proposed laws, all directly related to the practice of obstetrics and gynecology, were not accepted. These laws concerned Confidential and Privileged Nature of Investigative Studies, Surgical Sterilization, and Tberapeutic Abortion. Expected opposition to the latter two laws by Catholic lay groups and clergy was encountered.

The Twelfth Annual Postgraduate Obstetric-Pediatric Seminar was held at St. Petersburg Beach, August 16-18, 1962. Attendance was high in spite of encepbalitis publicity. The faculty and program were outstanding. The State of Mississippi participated as a member for the first time. The Thirteenth Seminar will be held in Daytona Beach,

August 22-24, 1963.

The Florida Obstetric and Gynecologic Society has been one of the first specialty groups to formulate its own legislative program and to present these proposed laws to the Association's Committee on State Legislation. The much overworked legislative committee rightly accepted for presentation the one law affecting all physicians in the state-Privileged Communication. This policy, particularly during a disorganized new legislature, is understandable. The specialty, however, is again left witbout much-needed This circumstance could easily repeat itself year after year. Other specialty groups will in the future request essential laws relating only to themselves. Such laws should be presented to the legislature by the legislative committee and not by the individual specialty groups. This Committee asks recognition of this problem and solicits the continuing aid of all interested physicians and of the legislative committee in passage of laws relating to the specialty groups,

Recommendations:

7. That in formulating the Florida Medical Association's legislative program each year, the Committee on State Legislation be requested to consider, in addition to general measures affecting the entire medical profession and the public, bills of importance to, and submitted by, the various state medical specialty groups.

9. COMMITTEE ON MENTAL HEALTH

The Committee has had an active year, with three Committee meetings; 60 per cent of the Committee members attended and participated in the American Medical Association's First National Congress on Mental Health and Illness in Chicago, October 3 and 4, 1962.

The Chairman presented a paper at the American Medical Association's Ninth Annual Conference of State Mental Health Representatives in Chicago, March 1 and 2, 1963. The Committee's role as consultant has been its most significant work this year. It was represented at the American Psychiatric Association's hearings surveying the mental health facilities in the state, was invited to serve as consultant to the Florida Legislative Council's Legislative Subcommittee on Mental Health, and was represented at 80 per cent of the meetings. The subcommittee was considering legislative and administrative programs to improve and expand facilities for diagnosis and treatment of mentally ill or disturbed patients. Numerous informal discussions were attended, in addition to the formal subcommittee meetings. These several activities superseded the annual conference of heads of state agencies.

Recommendations:

 That early priority be given to the establishment and operation of inpatient treatment facilities for psychotic and emotionally disturbed children in Florida.

9. That the Florida Medical Association assume the leadership role in a program by which elderly, nonpsychotic patients could be removed from state bospitals and cared for at local levels, if such move would not be detrimental to the health and wellbeing of such patients.

 That the Florida Medical Association and the component county medical societies play an active role in advising and encouraging legislative and administrative action at state and county levels to improve facilities for community-oriented diagnosis and treat-

ment of mental health problems.

11. That the Florida Medical Association support the American Medical Association Council on Mental Health's program for nationwide improvement of mental health facilities for diagnosis and treatment, by establishing and expanding community-oriented, and community-operated facilities.

12. That the Florida Medical Association adopt a long range program fostering the cause of improved mental health in the state, and utilize its facilities to assure implementation of such programs as are necessary and practicable to improve quality and quantity of diagnostic and treatment facilities for the mentally ill, locally.

10. COMMITTEE ON PUBLIC HEALTH

During the year three matters were referred to the Committee for consideration. All were reviewed by the full Committee by letter and by telephone with the following unanimous recommendations which were transmitted to

the bodies requesting them.

First, L. K. Ireland, fiscal analyst, proposed a bill providing that administration of the various county health departments be transferred from the State Board of Health to each of the various boards of county commissioners. The Committee disapproved this bill and recommended that the present basic public health structure of the State of Florida should not be changed. This recommendation was transmitted to the Board of Governors.

Second, a resolution of the Pinellas County Medical

Second, a resolution of the Pinellas County Medical Society concerning cigarette smoking was considered, and appropriate recommendations were made to the Council on Medical Services, to which the resolution was referred.

11. COMMITTEE ON RURAL HEALTH

The Chairman attended some seven state and national meetings and conferences in behalf of the Committee during the year. These meetings covered a wide range of rural health-related subjects. He also participated in a panel discussion on problems in common between medicine and agriculture at the Fifth Annual Conference of County Medical Society Presidents and Secretaries held January 17, 1963.

Recommendations:

 That each county medical society have an active rural health committee or at least one individual member interested and active in this field.

14. That these committees or individuals survey conditions in their areas and take the lead in forming joint rural health councils composed of community civic, professional and agricultural leaders, including the rural health committee of each local Farm Bureau.

 That local county medical societies promote either county or statewide laws requiring inoculation of

dogs and cats against rabies.

16. That an all-out educational campaign against the use of shallow wells be considered, with the objective of bringing to rural dwellers' attention the dangers presented by the use of septic tanks and shallow wells.

12. COMMITTEE ON VISION

The major activities for the year have been cultivating medically supervised eye screening in schools and promotion of glaucoma screening in the state's adult population

above 40 years of age.

The Committee began its efforts of attempting to install a medically supervised program of eye screening in all the schools of the State of Florida five years ago. Well over half the counties now have an acceptable program. The Committee is working to make all these programs uniform and to extend the practice to all schools of all counties. Each summer, information on initiating these programs is mailed to each county medical society and county health officer. The Committee offers further information and instruction in these methods to anyone requesting it.

In 1960, the Committee reported on efforts in mass screening for detection of early chronic glaucoma. The

House of Delegates at that time endorsed these efforts. Glaucoma screening has been done in Miami, West Palm Beach, Fort Lauderdale, Pensacola, Ocala, Tampa, St. Petersburg, Port Charlotte, Sarasota, Orlando and Lakeland. Most of these have been short term programs. The Miami, Sarasota, Orlando and Lakeland programs are the main continuous programs. A total of over 35,000 people has been screened for glaucoma, and an incidence of a little over 2 per cent has been found. Of all the screenings, over 8,000 have been done in Orlando and over 10,000 in Lakeland. Follow-up on glaucoma suspects has been generally poor in short term programs and generally good in continuous programs. The best follow-up has been obtained when done by the county health departments on a continuous basis.

The Committee believes that an incidence of over 2 per cent of a serious chronic disease which is readily detectable by a quick screening process makes glaucoma screen-

ing a very worth while public health effort.

Recommendations:

17: That work be continued in expanding eye screening in schools.

8 That medically sound programs of glaucoma screening be made available throughout the state as early as

possible.

19. That the Florida Medical Association and its component county societies make every effort to keep these programs under the competent medical supervision which they should have.

Recommendations of Council for House of Delegates' approval:

20. That a copy of a resolution regarding formation of a Committee on Trauma, which had been referred to the Council on Medical Services by the President of the Association, be referred in turn to the Florida Association of General Surgeons, with an expression of doubt as to the need for such a committee.

"The Reference Committee considered and approved Resolution 63-16 on Chamber of Commerce. This resolution was in the Delegates' packets.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 63-16 Chamber of Commerce

Orange County Medical Society

WHEREAS, Chambers of Commerce represent a strong force toward developing and continuing our free enterprise system; and

WHEREAS, Chambers of Commerce are dedicated to the improvement of the general welfare of our com-

nunities; an

WHEREAS, Chambers of Commerce depend upon and need the talents, resources and general support of the business men and professional men of the community; therefore, be it

RESOLVED, That the Orange County Medical Society recommend that its members endorse and support the Chamber of Commerce of its community; and be it

further

RESOLVED, That the Orange County Medical Society recommend that each physician affiliate himself with his local Chamber of Commerce to work for the accomplishment of mutual objectives; and be it further

RESOLVED, That a copy of this resolution be forwarded to the Florida Medical Association for consideration of a similarly worded resolution on a state level.

"The Reference Committee recommends that Resolution 63-20 be amended to read:

"Whereas, many pharmacists in the state of Florida may not be aware of the laws relating to refills of prescriptions, i.e. The Durham Humphrey's Amendment 1952 and Florida State laws, and

"Whereas, many prescriptions of deceased or ill physicians not in practice continue to be filled by pharmacists

in the state of Florida contrary to law, and

"Whereas, many prescriptions are filled at a different locality from that of the prescribing physician and the prescribing physician loses contact with the original pharmacy and cannot control refills of prescriptions; therefore, be it

"RESOLVED, That the Florida Medical Association pursue through the proper state or federal enforcement agencies full compliance with the laws and, if no law applies, introduce and support legislation to support the

following criteria:

"1. Any prescription not labeled as to refills may not be refilled.

"2. Any prescription labeled PRN or ad lib may not be refilled

"BE IT FURTHER RESOLVED, That the Florida delegates to the American Medical Association carry a similar resolution to the American Medical Association for nationwide enforcement or implementation.

"Mr. Speaker, I move the adoption of this portion of the report."

Dr. Curtis D. Benton Jr., of Broward: "As a representative of Broward County and also as a member of this Reference Committee, I realize that in our recommendations we have failed to recommend something to take care of part of the whereases. These recommendations do not solve the problem of prescriptions being filled away from the source of writing. We need to introduce a point to cover this and I would refer this back to our chairman."

Dr. Zellner: "I would like to point out that this is not a completely unobjectionable recommendation. For instance, there are many people who are diabetics. You cannot buy insulin or Orinase; you cannot buy thyroid extract without a prescription. Most doctors do not want to prescribe these in massive amounts, because this material is not stable. If this is passed by us and becomes law, it means that every doctor taking care of diabetics will have to see them or be called by them every two or three weeks."

Dr. Emmet F. Ferguson Jr., of Duval: "I looked at this the same way Dr. Zellner did, but the more I thought about it, you could write 10 to the sixth power. In other words—a hundred times or a thousand times—this does not solve anything."

Dr. John M. Gunsolus, of St. Lucie-Okeechobee-Martin: "This is our resolution. I wonder how many gentlemen in the audience here have prescribed PRN prescriptions, which are illegal according to the Durham Humphrey amendment of 1952, which has never been tried in court. As far as the diabetic is concerned, and Dr. Zellner's question, there is no restriction. You can mark this prescription to refill 12 times, 20 times, or x to the umteenth power, but at least you leave the control with the physician. But if the prescription is labeled PRN, it may be refilled by a diabetic for 10 or 11 years without ever coming in for a check. This becomes a very serious problem. All we are asking for is enforcement of the law which is already on the books."

Dr. Cook: "That was the understanding of the Committee, that this is already a law, and we are asking only for enforcement of a law which is already on the books."

Dr. Edward L. Cole Jr., Vice President: "I think there should be another whereas: 'Whereas the use of drugs without the knowledge of the prescribing physician may be to the detriment of the health of the patient;"

"I move to add this as an amendment to the motion."

The amendment carried.

The motion carried as amended.

Resolution 63-20 Refilling of Prescriptions St. Lucie-Okeechobee-Martin County **Medical Society**

WHEREAS, many pharmacists in the state of Florida may not be aware of the laws relating to refills of prescriptions, i.e. The Durham Humphrey's Amendment 1952 and Florida State laws; and

WHEREAS, many prescriptions of deceased or ill physicians not in practice continue to be filled by pharmacists in the state of Florida contrary to law; and

WHEREAS, many prescriptions are filled at a different locality from that of the prescribing physician and the prescribing physician loses contact with the original pharmacy and cannot control refills of prescriptions; and

WHEREAS, the use of drugs without the knowledge of the prescribing physician may be to the detriment of

the health of the patient; therefore, be it

RESOLVED, That the Florida Medical Association pursue through the proper state or federal enforcement agencies full compliance with the laws, and if no law applies, introduce and support legislation to support the following criteria:

1. Any prescription not labeled as to refills may not be refilled.

2. Any prescription labeled PRN or ad lib may not be refilled. BE IT FURTHER RESOLVED, That the Florida delegates to the American Medical Association carry a

similar resolution to the American Medical Association for nationwide enforcement or implementation.

Dr. Cook: "Mr. Speaker, I move the adoption of the entire report as amended."

No discussion: no objections, motion carried.

Dr. Peek resumed the Chair and made the golf awards. The Duval Trophy was awarded to Dr.

Truxton L. Jackson for the low net score and the Orlando Cup to Dr. Julian A. Rickles for the low gross score. Gift certificates were awarded to other winners in the golf tournament.

Three prizes were awarded as a result of drawing of names for exhibit visitation. First prize went to Dr. Louis J. Polskin, second prize to Dr. Bernard J. McCloskey and third prize to Dr. Robert L. Levine.

Dr. Day announced that the exhibitors were delighted with the interest shown in this contest. It helped visitation to the exhibits. Next year the hotel is going to give a free week as its guest, with U-Drive-It and a few other things to go along with it.

Dr. Evans resumed the Chair.

Report of Reference Committee No. III

Finance and Administration

Dr. W. Dean Steward: "Mr. Speaker and Members of the House of Delegates: The Reference Committee on Finance and Administration has considered each of the items referred to it, and desires to present the following report. The Reference Committee's recommendations on each item will be submitted separately, and I respectfully suggest that each item be acted upon before going to the next.

"The Reference Committee considered the Report of the Board of Governors, with the exception of the portion concerning Blue Shield contracts which was referred at the First House of Delegates to Reference Committee No. IV, and recommends approval of all but that portion of the report as printed in the Handbook. In addition to this report your Reference Committee recommends that steps be taken by the Subcommittee on Quackery to carry out a vigorous and constructive educational program, statewide, to combat quackery in all forms.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Report of the Board of Governors

ROBERT E. ZELLNER, Chairman

During the Association's administrative year and prior to the printing of this report four meetings of the Board of Governors have been held. They were at Bal Harbour on May 13, 1962, Montego Bay, Jamaica, British West Indies, on September 21-23, 1962 and Jacksonville on January 12 and April 7, 1963. If it is necessary to hold another meeting of the Board prior to the Annual Meeting, it will be covered in a supplemental report and presented to the first meeting of the House of Delegates on May 16, 1963.

The Chairman wishes to express deep appreciation to the members of the Board of Governors, and Council and Committee members who have conducted the business of the Association this year at great personal sacrifice of time, and diligently worked for the promotion of the programs of the Association. It has been a privilege to have the opportunity to be associated and work with these outstanding and dedicated physicians.

MAJOR ACTIVITIES

ANNUAL MEETING.—The House of Delegates on May 13, 1962 authorized the Board of Governors to change the meeting place of the 1963 Annual Meeting. The Board, on May 13, 1962, changed the 1963 Annual Meeting from Jacksonville to the Diplomat Hotel, Holly-wood-by-the-Sea, for the dates of May 16-19. The Board approved the program and schedule for the 1963 Annual Meeting submitted by the Committee on Scientific Work. The scientific program again this year will be presented in cooperation with a number of special interest groups. In an attempt to increase the attendance at the Annual Meeting and visitation of exhibits, your board approved a special promotional program for the Annual Meeting which includes its designation as the "Million Dollar Meeting" and three special exhibits visitation awards which will be one day's interest on a million dollars. Your Board released the dates of May 13-17, 1964 and confirmed the dates of May 6-10, 1964 for the Annual Meeting at the Diplomat Hotel, Hollywood-by-the-Sea.

BUDGET.—The Board carefully reviewed the financial statement and audited statement prepared by the Secretary-Treasurer and Executive Director, In 1962 the Association had an income from all sources of \$249,-155.22; total expenses incurred were \$224,883.13, for a net excess of income over expenses of \$24,272.09. The Board approved an annual operating budget for the calendar year 1963 in the amount of \$253,127.00 plus 5 per cent for reserve and \$10,000.00 for reserve toward expenditures for the building addition which is \$22,500.00, for a total of \$275,627.00. This budget was presented by the Executive Director after consultation with the Secretary-Treasurer, amended by the Board, and based upon an anticipated income of \$275,000.00.

HEADQUARTERS BUILDING.—Your Board authorized an addition to the Association's headquarters building in Jacksonville because of the problem of inadequate space which had resulted from the growth of the Association. The building program was completed in February 1963 and added approximately 2,000 square feet to the existing building.

PRESIDENTS' AND SECRETARIES' CONFER-ENCE.—The Board sponsored the Fifth Annual Conference for Presidents and Secretaries of county medical societies on January 12-13, 1963. Twenty-eight county medical societies were represented at the conference this year and represented 96 per cent of the total membership of the Association.

APPOINTMENTS.—On May 13, 1962 the Board appointed Burns A. Dobbins Jr., M.D. as the AMA delegate to serve on the Board of Governors; approved the Presi-

dent's appointment of Leo M. Wachtel, M.D. to serve as Public Relations Officer; approved the President's appointment of H. Phillip Hampton, M.D. as optional member of the Executive Committee; appointed Thad Moseley, M.D. as Editor of The Journal, accepted the Editor's nominations and appointed Charles K. Donegan, M.D., John M. Packard, M.D. and Franz Stewart, M.D. Assistant Editors of The Journal; requested Courtlandt D. Berry, M.D. to serve as fraternal delegate to the Medical Association of Puerto Rico; reappointed the Committee on Research, and appointed a key contact physician and alternate for each member of Florida's congressional delegation.

PRESIDENT-ELECT AMA.—Vour Board expressed appreciation to officers of the Minnesota, Iowa, Nebraska, and South Dakota medical associations for a letter sponsoring Edward R. Annis, M.D. for election as President-Elect of the American Medical Association and also expressed appreciation to the California Medical Association for its assistance in his candidacy. Dr. Annis was elected President-Elect of the AMA in June 1962.

OSTEOPATHY.—Your Board approved the activities of the Executive Committee regarding the osteopathy problem and adopted the following report which was contained in a letter to the Florida Association of Osteo-

pathic Physicians and Surgeons:

"In accordance with our previous agreement this letter is written to appraise you of the findings of the Executive Committee of the Board of Governors with respect to medical licensure for osteopaths who have been recently granted degrees of doctor of medicine by the recently converted California College of Osteopathy and for other osteopaths who would like to acquire degrees of doctor of medicine. In order to make the picture completely clear, it will be necessary to outline the entire problem.

"The right to practice medicine is a privilege granted and controlled by the State through its Board of Medical Examiners, who serve by gubernatorial appointment. Their responsibility is to the State. A medical degree is an academic degree granted by a college of medicine, which sets its own requirements for eligibility and for the granting of this degree. The Florida Medical Association is a voluntary professional association of doctors of medicine whose avowed purpose is to provide a vehicle for the increase in the professional excellence of its members and for service to the public. Its membership is restricted to doctors of medicine.

"I have conferred with the Executive Director of the State Board of Medical Examiners, Dr. Homer Pearson, concerning permitting those osteopaths who have been granted an M.D. degree in absentia by the California school to take the medical examination. He informed me that Florida statute requires that to be eligible to take the examination an applicant must be a graduate from an accredited medical school. The Board has ruled that graduates of the California School of Osteopathy prior to the date of its conversion to a medical school are in fact graduates of a school of osteopathy; therefore, they are not eligible to take the examination. Subsequent graduates of this school will be eligible.

"Conferences have been held with the deans of the medical schools in Florida concerning what their requirements would be for granting M.D. degrees to osteopaths. The University of Florida will treat applications from osteopaths for admission to the medical school on the same basis as all other applicants and will require a full four years of instruction before it will grant a degree. You will be interested in knowing that it treats dentists in the same manner. The University of Miami will consider applications for admission to its medical school from individual osteopaths and will give individual evaluation to each applicant.

"Under existing circumstances it appears that osteopaths who desire to practice as doctors in Florida under the Medical Practice Act would be required to acquire an M.D. degree as an in-residence student at an accredited school of medicine. The entrance to medical school requirements would be subject to individual consideration by each medical school and for each applicant. I do not believe that under the present circumstances there is any further action that can be taken by the Florida Medical Association. If there is any further clarification on this matter that you would like, I would be glad to hear from you."

Your Board further approved the opinion expressed in a President's letter to the chairman of the board of trus-

tees of a hospital:

"The Board of Governors of the Florida Medical Association has interpreted the sentence 'Until the present overall situation throughout the State changes, our attitude withholding professional recognition of osteopaths as a group must be maintained to include individual osteopaths as well as groups unless otherwise required by law. There are a few counties in which osteopaths act as county physicians, in which cases it is sometimes necessary for a doctor of medicine to deal with osteopaths as county officials. The granting of hospital privileges is a function of individual hospital boards and as such is not subject to approval of the Florida Medical Association. Where osteopaths are admitted to practice in a hospital in which doctors of medicine practice, it has been held to be unethical for the doctor of medicine to have any professional relationship with the osteopath. This includes consultations, supervising the work of the osteopath through review of medical records, tissue committees, etc. or giving any other indication of professional recognition.

"Since the Florida Medical Association does not evaluate the competence of individual practitioners of a healing art, it is held that the individual county medical societies are not competent to do so either."

ASSOCIATION'S SEAL.—Officially adopted a new

seal for the Association.

PRESCRIBED MEDICINE PROGRAM.—The Board disapproved obligatory use of a formulary for prescribed medicine for public assistance recipients and advised the Medical Advisory Committee to the Department of Public Welfare that the Association would be glad to cooperate in an educational program for physicians.

SEROLOGIES.—The Board disapproved the proposed legislation regarding mandatory reporting of positive serologies by laboratories to the State Board of Health.

COMMUNITY SERVICE AWARD.—The Board reviewed the nominations received from county medical societies and selected the recipient for the A. H. Robins Company Award "For Outstanding Community Service by a Physician," to be presented at the first meeting of the House of Delegates, May 16.

MEDICARE.—The Board adopted the following policy regarding a new Medicare contract to become effective May 1, 1963: That in approving a new Medicare contract the Florida Medical Association representatives be authorized to negotiate with the Office for Dependents Medical Care for reconciliation of differences in nomenclature and code numbers but not in relative value points.

COUNCIL AND COMMITTEE REPORTS

During the past year a great deal of time and effort was put forth to implement the policy set forth by the House of Delegates in coordinating the activities of the various Councils and Committees. Your Board authorized and directed the chairmen of the Association's Councils that they were to accept reports from the Committees, edit, summarize, consolidate and present them for publication in the Delegates' Handbook. The Board further reminded the Council and Committee chairmen that everything must be cleared through the Council and in turn through the Board of Governors before being transmitted to outside agencies, or organizations or individuals. The Board on April 7 carefully reviewed and edited all Council and Committee reports to be transmitted to the House of Delegates in the Delegates' Handbook. Specific action regarding Council reports during the year are as follows:

LEGISLATION.—The Board approved the recommendations of the Council on Legislation and Public Agencies for further implementation of Kerr-Mills legislation by the 1963 session of the Florida Legislature with congratulations and appreciation for its extensive work.

FEE SCHEDULES.—The Board authorized publication of the 1962 FMA Relative Value Studies as presented

by the Committee on Fee Schedules.

SPECIALTY GROUPS.—The Board approved the recommendation of the Council on Specialty Medicine and granted official recognition to the Florida Society of

Physical Medicine and Rehabilitation.

DELEGATE TO MEDICAL ASSOCIATION OF PUERTO RICO.—Reviewed the report of Courtlandt D. Berry, M.D., the Florida Medical Association delegate to the annual meeting of the Medical Association of Puerto Rico, and commended him for the excellent report

NATIONAL LEGISLATIVE PROGRAM.—The Board approved in principle the National Legislative Action Program for 1963-1964 to be conducted by the Association, its county medical societies and the Woman's Auxiliary.

VOLUNTARY HEALTH AGENCIES.—In compliance with the By-Laws of the Association and rules adopted by the Board, approval was given to the recommendation of the Council on Voluntary Health Agencies and official recognition granted to the Florida Society for the Prevention of Blindness.

NOMINATIONS

BLUE SHIELD BOARD OF DIRECTORS.-The Board of Governors reviewed the nominations for the Blue Shield Board of Directors, prepared by the Blue Shield Nominating Committee, and from the nominations for each physician directorship the following two were

Medical District "A"

Three year term Leo M. Wachtel, M.D. Gretchen V. Squires, M.D.

Medical District "B"

Three year term William J. Dean, M.D. Abbott Y. Wilcox Jr., M.D.

Medical District "C"

Three year term John R. Mahoney, M.D. W. Dotson Wells, M.D.

At Large

Three year term Edward L. Cole Jr., M.D. V. Marklin Johnson, M.D.

The two lay members nominated by the Nominating Committee were approved by the Board as follows:

District "A" Three year term Hon. Ben C. Willis District "B" Three year term Mr. William M. Hollis

RECOMMENDATIONS

BY-LAWS.—After careful consideration, the Board of Governors recommends to the House of Delegates the following amendments to the current By-Laws of the Florida Medical Association:

1. Amend Chapter IX, Section 2, by deleting Subsection 1, and renumbering subsections 2-15 as 1-14. (Explanation: This amendment, requested by the Council on Allied Professions and Vocations, provides that committees of that Council be regular standing committees, rather than special standing committees-of-

Amend Chapter IX, Section 1, paragraph 2, to read as

"THE COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS. Committees on Dentistry, Law, Medical Assistants, Medical Technologists, Nursing, Pharmacy, Physical Therapy, Podiatry, Veterinary Medicine, and X-Ray Technicians."
(Explanation: This amendment changes the name of

the Committee on Medical Technicians to the Committee on Medical Technologists, as requested by the Council on Allied Professions and Vocations.)

3. Amend Chapter IX, Section 1, paragraph 5, to read as

follows:

"THE COUNCIL ON MEDICAL ECONOMICS: Committees on Blue Shield, Commercial Health Insurance, Fee Schedules, Occupational Health, Medicine, and Members' Insurance."

(Explanation: This amendment changes the name of the Committee on Industrial Medicine to the Committee on Occupational Health, as requested by that

Committee.)

4. Amend Chapter IX, Section 1, paragraph 9, to read as follows

"THE COUNCIL ON SPECIAL ACTIVITIES: Committees on Advisory to Woman's Auxiliary to the Florida Medical Association, Board of Past Presidents, and Delegates to House of Delegates of the American Medical Association."

Amend Chapter IX, Section 2, by adding an additional Subsection 10 as follows and renumbering subsections

10-15 as 11-16:

"10. Board of Past Presidents.-This Committee shall be composed of all living Past Presidents. The Chairman shall be selected by the Committee from among its membership."

Amend Chapter IX, Section 3, by adding an additional Subsection 16 as follows and renumbering Subsection

16 as 17:

"16. The Board of Past President shall provide liaison between the Association and the officers of the

component medical societies."

(Explanation: The above amendments abolish the Committee on Liaison with Component Societies and transer this function to the Board of Past Presidents. They also delineate the composition of the Board. It was requested by the Board of Governors on April 7, 1963, that this action be accomplished.)

5. Amend Chapter X, Section 2, Subsection 2, to read as

follows

"2. ENTRANCE FEE.—Each new active or associate member, except interns, residents and fellows in approved training programs approved by the American Medical Association Council on Medical Education and Hospitals, shall be required to pay an entrance fee of \$10.00 in addition to his annual dues.'

(Explanation: This amendment, requested by the Board of Governors, on September 21, 1962, permits waiver of the Association membership entrance fee for interns, residents and fellows in approved training

programs.)

POSTGRADUATE EDUCATION - The Board recommends to the House of Delegates that emphasis be placed by the Association on Postgraduate Medical Education. All such programs endorsed by the Association shall be coordinated, administered or approved by the Association through its Committee on Postgraduate Education in cooperation with the Florida Medical Foundation.

RESOLUTIONS

Several Resolutions are recommended to the House of Delegates for adoption and are contained in the Handbook as:

Resolution No. 63-2—Reference Committees Resolution No. 63-14—Hospital Boards Resolution No. 63-15-Interns and Residents

SUBCOMMITTEES OF THE BOARD

VENOMOUS SNAKE BITE.—The Board reviewed and approved the report of the Subcommittee on Venomous Snake Bite and requested that it not be published in the Handbook as the subject is being covered in an expanded form in the June issue of The Journal.

INTER-AMERICAN RELATIONS.-The Board approved the report of the Subcommittee on Inter-American Relations which follows as a part of the Board

"The Subcommittee on Inter-American Relations functioned as before as primarily a stand-by committee and the members of the Committee have been attempting to improve the relations with Latin American

physicians primarily on a local level. "On February 6, 1963, we visited Colombia on the doctor-to-doctor program and we visited the hospitals and lectured to the physicians at the University Hospital in Calli, Colombia. This program was a joint endeavor of the physicians and dentists in the Dade County area and included an assorted group of 25 physicians and dentists. Our visit was well received. and the physicians and dentists attending this tour came back with a better understanding of Latin American medical problems as well as a new respect for the physicians practicing in that area.'

QUACKERY.-The Board approved the report of the Subcommittee on Quackery which follows as a part of

the Board report:

"The Committee on Medical Quackery, after consultation with the Board of Governors at the fall meeting in Jamaica, West Indies, has formulated and initiated

the following program:

To investigate on a statewide program, medical quackery in the following three categories: a) Within the ranks of the licensed medical doctors of the State of Florida; b) As it pertains to other groups licensed under Florida statutes to practice the healing arts; c) As it pertains to the business community licensed by state, county and local corporate government, to practice so-called allied medical skills and or sell to the public any product having to do with the general field of health.

"The county medical societies of the State of Florida have been requested to establish a Committee on Quackery or to authorize a standing investigating committee to forward to the Florida Medical Association offices in Jacksonville any information obtained on quackery in the above three categories. This will create a central file from which this subject may be thoroughly reviewed.

"It is anticipated that the work of this committee will extend over a period of several years. When sufficient information is available, a report will be submitted to the Board of Governors of the Florida Medical Association

with recommendations of a remedial nature.

"The report of the Judicial Council and its Committees as printed in the Handbook, the supplemental report of the Judicial Council and the supplemental report of the Committee on Archives as presented in the Delegates' packets are approved.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Judicial Council

S. CARNES HARVARD, Chairman

Council:

The Judicial Council has held one meeting during the year. Another meeting is scheduled for the year and will be covered in a supplemental report to the House.

The House of Delegates authorized the issuance of charters to two new component county medical societies upon their adopting constitution and by-laws not in conflict with the Florida Medical Association's By-Laws, the determination of compliance to be made by the Judicial Council.

The physicians in Gadsden and Liberty counties applied for a separate charter, adopted by-laws which were approved by the Judicial Council, and their new charter was issued in January 1963. A new charter was issued to the Leon-Wakulla-Jefferson County Medical Society.

The other separate county medical society being considered has not submitted charter and by-laws, and its charter, authorized in 1962, has not been approved to

The Council has received requests for opinions in matters pertaining to medical ethics which have been rendered.

Supplemental Report of JUDICIAL COUNCIL

S. CARNES HARVARD, M.D., Chairman

One meeting of the Judicial Council was held on April 6, 1963, after the report for the Handbook had been compiled. At this meeting various disciplinary problems and an appeal were considered by the Council.

The following policy adopted by the House of Delegates

in 1962 was considered:

"We recommend to the Board of Governors that as radiologists, anesthesiologists, and pathologists are all doctors of medicine and are bound by the Principles of Medical Ethics the same as any other doctor of medicine, or group of physicians, if they have a contract with any hospital whereby their services are purveyed by the hospital, then the hospital is engaged in the corporate practice of medicine, which is illegal; the doctors are allowing themselves to be exploited and are violating the Principles of Medical Ethics of the American Medical Association and procedures must be taken against them."

Representatives of the Florida Society of Anesthesiologists, the Florida Society of Pathologists and the Florida Radiological Society were present at the Council meeting. Several suggested methods were discussed regarding this problem. Each of the three specialty groups was requested to prepare specific, concrete recommendations complete with details for presentation at a future meeting of the

Council.

Recommendations:

The Council has considered the request and desire of those members of the St. Lucie-Okeechobee-Martin County Medical Society residing in Martin County for a separate component county medical society of the Florida Medical Association, Inc., and recommends:

1. That a charter be issued to the Martin County

Medical Society.

That issuance of this charter be contingent upon this new society's adoption of Constitution and By-Laws or being incorporated with By-Laws not in conflict with the Articles of Incorporation and By-Laws of the Florida Medical Association, the determination of compliance with this provision to be made by the Judicial Council.

3. That the charter of the St. Lucie-Okeechobee-Martin County Medical Society be changed to the St. Lucie-Okeechobee County Medical Society.

The majority of the work this year has been carried out by the Committees of the Council. Their reports are as follows: Committees:

1. COMMITTEE ON ARCHIVES

The Committee on Archives had one meeting during the year, a round-table telephone conference, on March 26. Activities of the year were discussed as well as plans for an exhibit at the Annual Meeting.

The Committee has been very active this year, communicating with over 1,000 physicans in the 40-50 year age group in an effort to complete further the archives on the entire membership of the Association. To date, how-ever, we have been successful in obtaining replies from only 350 of this group.

Again this year, we have followed up on 184 members in the over-60 age group, and 524 members in the 50-60 year age group. It is our hope that these members will get the requested material in without further delay.

This year at the Annual Meeting, the Committee on Archives has an exhibit entitled "Florida-Territory to Statehood" which will include coins, currencies, letters, audits, charts, etc., pertinent to Florida and dating back to the early years. Included are some very old letters written by various statesmen and medical officers during the Seminole War as well as the War between the States We hope that each member who is at the convention will have the time to visit this exhibit. Should any of the members of the Association have historical records pertinent to the Florida Medical Association, the Committee on Archives would welcome them to complete further the Association's records.

The Association has lost many of its fine members during the past year, and their names are listed below, along with those of members who died in previous years but were not included in the Committee's reports:

May 1961

Harry F. Watt-Marion

September 1961

O. Frank Kleckner—Pinellas

November 1961

Philip F. Prioleau-Volusia

February 1962

Frank E. Daves-Leon-Wakulla-Jefferson

March 1962

H. Spurgeon Cherry—Lake

Joseph B. Davis-Volusia

May 1962

Malissa D. Browning—Dade

Frederick J. Fox—Lake

Roscoe H. Knowlton-Pinellas

Thomas O. Otto-Dade

Ralph M. Overstreet Jr.-Palm Beach

July 1962

David W. Harris-Broward

Jere W. Kirkpatrick—Pasco-Hernando-Citrus Robert C. Swartz—Dade

Wilfred J. White-Palm Beach

Henry P. Bevis—DeSoto-Hardee-Glades Grover C. Collins—Putnam

Louise M. DeVore—Dade

Frank D. Gray-Orange

Wilfred Lansman-Dade

Richard D. Shapiro-Dade

John C. Turner Sr.—Dade

September 1962

Julian E. Gammon-Duval

October 1962

John M. McDonald-Nassau

Laurance D. Van Tilborg-St. Lucie-Okeechobee-

November 1962

Mayhew W. Dodson—Escambia Paul W. Harrision—Clay

Vitol S. Shepard—Palm Beach

December 1962

Richard H. Walker Jr.-Orange

S. Elliott Wilson—Broward

January 1963

Joseph C. Frell—Dade John B. Seeds—Dade

Irving Spertus—Pinellas

February 1963

Percy L. Dodge—Dade

Tom R. Gammage—Dade John H. Wachal—Taylor

Supplemental Report of COMMITTEE ON ARCHIVES

CLIFFORD C. SNYDER, M.D., Chairman

Since the Handbook was compiled, the Association has lost the following members through death.

January 1963

Grace W. Parr-Pinellas

March 1963

Raymond R. Killinger Sr.—Duval Frederick F. Kumm—Pinellas Frank L. Meleney—Dade

Neal J. Phillips—Hillsborough

April 1963

Roland F. Phillips—Dade

Eugene H. Silverstone-Dade

C. Kirby Smith-Dade

2. GRIEVANCE COMMITTEE

The Grievance Committee for the Association has not had a meeting this year. It has not been necessary because of the fact that the local or the county medical societies and associations have done such an excellent job of handling their respective grievances.

3. COMMITTEE ON LICENSURE

During 1962 the Board of Medical Examiners examined for licensure 409 applicants; 380 received licenses and 29 failed.

Twenty-two hearings have been held, which resulted

in the following action being taken:

2 licenses suspended for two years (narcotic addiction) 7 licenses suspended for two years with suspension not enforced and physicians under suspension required

to appear before the Board each June and November. (1 maintaining association with person who continued to violate Medical Practice Act; fraud in the practice of medicine and unprofessional conduct -2 habitual use of intoxicating liquors-1 immoral

and unprofessional conduct—3 narcotic addiction) 2 reprimanded (alleged immoral and unprofessional conduct)

3 charges dismissed (1 narcotics violation-2 alleged immoral and unprofessional conduct)

3 licenses revoked (1 abortion-1 conviction of felony -1 habitual use of intoxicating liquors)

2 suspensions terminated at end of two year period

3 semiannual interviews with physicians on probation Figures on the annual registration vary from day to day. Military status changes, and physicians living out of the state decide to move and reinstate their licenses. Current figures for 1963 registration fee, which was due October 1, 1962, and delinquent after January 1, 1963,

1963 Registration Fee Paid-8,267 (241 physicians were delinquent and had to pay delinquency fee)

In active military service—404

Suspended for nonpayment of registration-622 (none of whom are in active practice in Florida)

Retired-143

4. COMMITTEE ON MEMBERSHIP AND DISCIPLINE

A called meeting of the members of the Committee on Membership and Discipline from District 5, and your Chairman, was held in Dade City at 1:30 p.m., October

S. Carnes Harvard, M.D., Chairman, Florida Medical Association Judicial Council; Harry T. Gray Esq., legal counsel for the Florida Medical Association, and Harold Parham, Executive Director, were also present.

Two cases were presented for consideration at this meeting.

The first was a case of personal misconduct which was reported to the Judicial Council for transmission to the State Board of Medical Examiners for its consideration.

The second case was one for violation of the Principles of Medical Ethics. No action was deemed necessary by the disciplinary committee at this time.

"Resolution No. 63-2, Reference Committees, which was originally referred to our Reference Committee, was not considered in view of the fact that it was approved by the First House of Delegates. We do, however, approve wholeheartedly the intent of this resolution and appreciate the open and frank intramural discussion which it permits.

"Resolution 63-7, Osteopathy, printed in the Handbook on page 54, was carefully considered by your Reference Committee. The Committee believes that among other things, this resolution was presented in order to point out that we have a problem in this area which must be faced and brought out in the open in order that clarification of the feeling of the Florida Medical Association be obtained at its House of Delegates. It was the unanimous feeling of the Reference Committee that the published position of the Board of Governors regarding osteopathy and all cults be reiterated and endorsed. In addition, there was some question of the validity of the 'Whereases' in the resolution.

"It is the unanimous recommendation of the Reference Committee that this resolution be disapproved in its entirety and not be published in The Journal.

"Mr. Speaker, the Committee recommends that Resolution 63-7 not be adopted."

Dr. Thad Moseley, of Duval: "Purely for information—in The Journal of November 1961, Dr. Collins, of Orlando, following an executive Board meeting of this organization at which the original decision on osteopathy was made, wrote an editorial which gave him a little leeway of expression, which I think is one of the best expressions of the semiofficial feeling of the Florida Medical Association concerning this problem. I would recommend that each of you would find this issue and read this editorial. It is very well worded."

Dr. Dobbins, of Broward: "I would like to move that the Editor of The Journal be requested to republish that editorial."

Dr. Evans: "I would rule the motion out of order, although the suggestion is a good one."

Dr. Moseley: "We accept the suggestion." Motion carried.

Dr. Steward: "Resolution 63-23, Cults, as presented at the First House of Delegates is disapproved. Inasmuch as this resolution treats a variety of subjects, it is recommended that those subjects not treated elsewhere be submitted in separate resolutions.

"Mr. Speaker, the Committee recommends that resolution No. 63-23 not be adopted."

Dr. Marshall E. Smith, of Hillsborough, asked that the resolution be read so that the House would know what it was voting on.

Dr. Evans read the "Resolved" portion of the resolution.

Motion carried.

"The Reference Committee would like not only to commend the Speaker of the House, Dr. Peek, for his well chosen and equally well received remarks at the First House of Delegates, but to congratulate him for his expeditious handling of the business presented at that meeting.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "We would like to thank our President for his timely address, which made us pause for reflection on the fundamental ethics of medical practice, which in these busy days many of us are prone, at times, to forget.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. (The full text of the President's Address starts on page 19 of this issue.)

"Mr. Speaker, I move the adoption of the Committee's entire report."

Motion carried.

Dr. Steward thanked the members of his Committee: Drs. George S. Palmer, Gordon H. Mc-Swain, L. Washington Dowlen, Joseph C. Von Thron and Jere W. Annis, Advisory.

REPORT OF REFERENCE COMMITTEE NO IV

Legislation and Miscellaneous

Dr. James F. Cooney, Chairman: "Mr. Speaker and Members of the House of Delegates:

"Reference Committee No. IV on Legislation and Miscellaneous has considered each of the items referred to it and makes the following report:

"The two opening paragraphs of the report of the Council on Legislation and Public Agencies are approved as printed in the Handbook. We recommend that paragraph 3 (page 41 of the Handbook) be deleted, as the supplemental report was not included in the Delegates' packets.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

"The report of the Committee on State Legislation is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"In the report of the Subcommittee on Liaison with State Agencies, the first portion dealing with Alcoholic Rehabilitation is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "In the section of this report dealing with Vocational Rehabilitation, the Reference Committee recommends that the last paragraph be deleted, and the remainder approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

"The section dealing with Crippled Children's Commission is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Legislation and Public Agencies

H. PHILLIP HAMPTON, Chairman

Council:

The Council on Legislation and Public Agencies has had continued interest and activities regarding full im-

plementation of the Kerr-Mills Law in Florida. During the year, all Florida Congressmen were repeatedly contacted and advised of organized medicine's opposition to any plan to provide a health care program financed through use of the Social Security Tax System. Recently all Congressmen were visited in their Washington offices by officers of the Florida Medical Association and its key contact physicians. They were reminded that should they receive correspondence from constituents regarding lack of medical care because of inability to pay for it, such letters should be referred to the key contact physician for follow-up and assistance in obtaining needed medical care

for deserving cases.

While this group was in Washington visiting with the Florida delegation, Congressman Syd Herlong arranged for a conference with Mr. Wilbur Cohen, Assistant Secretary of Health, Education, and Welfare, Mrs. Ellen Winston, Commissioner of Welfare, and Mr. John Hurley, Acting Director, Bureau of Family Services, Department of Health, Education, and Welfare. The purpose of the conference was to obtain clarification from the Department of Health, Education, and Welfare regarding residency requirement as concerns implementation of a Medical Assistance for the Aged (MAA) program under the provisions of the Kerr-Mills Law. The officials of this Department advised that the Kerr-Mills Law does not permit inclusion of a specific time factor in determination of residency for eligible applicants for MAA benefits. It was suggested that the proposed Florida plan include the wording "Residing in the state or temporarily out of the state but deemed to be a resident," and further that the matter of residency determination be left to the Florida Department of Public Welfare to be administered by regulation rather than by law.

COMMITTEE ON STATE LEGISLATION: The House of Delegates, at the time of the May 1962 Annual Meeting of the Florida Medical Association, adopted the following as the legislative program for the 1963 session of the Florida legislature:

(1) Implementation of Kerr-Mills Law. A state plan to permit federal reimbursement under the Public Law 86-877 (Kerr-Mills) for expenditures made by the state and counties for aged needy sick under the existing Florida program of "Hospital Services for the Indigent."

The purpose of this legislation is to implement further the Kerr-Mills Law in Florida by creating a Medical Assistance for the Aged (MAA) pro-

(2) Insurance Program for Aged Persons. A state plan to aid by partial payment of the monthly premium for adequate health insurance for the aged who have assets inadequate to provide for themselves in case of serious illness.

This proposed legislation is to be offered as a supplement to Item 1 and is designed to provide legislative authorization for a state plan of aid to needy aged persons in the purchase of hospital and medical care insurance.

The following items were also adopted as part of the Association's legislative program; however, priority and major attention are to be directed toward passage of legislation to implement further the Kerr-Mills Law by creating a Medical Assistance for the Aged program.

Good Samaritan Legislation is intended to provide legal immunity for any licensed doctor of medicine who in good faith renders emergency care at the scene of an accident.

This legislation is modeled after that passed by eight states and is currently pending in a number of others. The purpose is to encourage physicians to respond in times of medical emergency by providing immunity from civil libel for care rendered at the scene of emergencies.

4) Privileged Communications bill is intended to define and establish the right of privileged communications between patient and physician. The purpose of the bill to be introduced is to provide similar statutory rights for physicians by adding a new section (Section 90.242) to Chapter, 90, Florida Statutes, covering ministers.

Privileged communications laws relating to physician-patient relationship have been passed by 36 of the 50 states. Such laws vary in scope from those which prohibit any disclosure by a physician without the patient's permission to those providing that a physician must answer any question about a patient if he is directed to do so by the presiding trial judge. Several states follow an intermediate position by providing a privileged communications law with exceptions covering conditions the revelation of which would cause shame and disgrace to the patient. Examples of limited communications statutes are: 1) New Mexico, which restricts the privilege primarily to venereal and loathsome diseases, and 2) Georgia, which protects only confidences made to psychiatrists. These two examples cause little interference to the proper administration of justice. In the State of Florida ministers of religion of the various recognized religious organizations and denominations usually referred to as churches are not allowed or required, in giving testimony as witnesses in any litigation, to disclose any information communicated to them in a confidential manner

As previously, the Association will maintain a headquarters office in Tallahassee at the Holiday Inn Motel during the entire legislative session. Mr. Al James, Assistant Executive Director, will be available at all times to provide information regarding legislation of interest to the Association as well as health care and other legislation of interest to individual physician members. During each week of the legislature, a bulletin summarizing the current status of legislation of interest to the medical profession will be mailed to all county medical societies.

Your Chairman again reminds that the success of the Association's legislative program depends entirely on the efforts put forth at the Jocal county medical society level.

COMMITTEE ON STATE LEGISLATION-

Subcommittee on Liaison with State Agencies

Alcoholic Rehabilitation.—We have held lengthy meetings every one to two months of the year. We have been actively engaged in setting policy, planning, and reviewing the Inpatient Program at Avon Park, as well as the Outpatient Clinics in the metropolitan areas.

Plans for cooperative work with counties have been implemented. There have been continued cooperative services in conjunction with Alcoholics Anonymous, the Florida Probation and Parole Commission, Division of Vocational Rehabilitation. Department of Education, and Florida State Board of Health as well as various communications media.

The Subcommittee has been actively reviewing the problem of treatment of the involuntary or criminal offender alcoholic. Various legislative proposals have been reviewed, and at the present time we have not found one which we feel we can recommend.

Vocational Rehabilitation.—The Chairman attended the meeting of the Medical Advisory Committee to the Division of Vocational Rehabilitation held in Jacksonville on October 14, 1962. The resolution which had been submitted by the House of Delegates concerning selection of the panel members was in effect rejected by the Subcommittee on Standards for Panel Specialists, and the Board of Governors of the Florida Medical Association was requested to define more clearly the words "fully accredited hospitals" as used in the resolution.

At a meeting of the Board of Governors, January 12, 1963, the Board unanimously agreed that the resolution is clearly worded and no other action by the Board is necessary.

The Chairman also visited the chairman of the Subcommittee on Standards for Panel Specialists in the month of October 1962, when a long discussion was held and when it was agreed that the provisions of the resolution adopted by the 1962 House of Delegates be reconsidered at the spring 1963 meeting. This meeting is to be held March 10, 1963, and a supplementary report will be filed concerning the actions at this meeting.

Crippled Children's Commission.—The Crippled Children's Commission during the past year has carried on its usual activities within budget limitations. One new district was established with a district office loated in Lakeland.

It is recommended that any specialty group of physicians which desires a program having to do with indigent children, and financed by the Crippled Children's Commission, first have the approval of the Board of Governors of the Florida Medical Association before presentation to the Commission.

"Each section of the report of the Council on Medical Economics was considered separately.

"The report of the Committee on Advisory to Blue Shield is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "The report of the Committee on Commercial Health Insurance is approved as printed in the Handbook, with the addition of the following.

"Whereas, the Florida Commission for the Cost of Medical Care has approved in principle the establishment of utilization committees in hospitals throughout the

State of Florida; therefore, be it "RESOLVED, That the House of Delegates of the Florida Medical Association approve this recommendation of the Florida Commission for the Cost of Medical Care, and request its component county medical societies to recommend the establishment of utilization committees and assist in the establishment of these committees.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried. "The report of the Committee on Fee Schedules is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried. "The report of the Committee on Industrial Medicine is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion: no objections, motion carried. "The report of the Medicare Mediation Committee is amended as follows: The last paragraph is amended to read:

'The present Medicare contract expired on April 30, 1963 and has been extended for one month. Negotiations are now in process for a new contract.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried. "The report of the Committee on Members' Insurance is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"The Reference Committee recommends that the recommendations of the Council on Medical Economics be amended by deleting entirely the first paragraph on page 48 of the Handbook. With this one deletion, all the recommendations of the Council are approved.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Dr. Cook, of Jackson-Calhoun, asked for an explanation. Dr. Cooney replied that this would leave the service limit exactly the same as it is now-\$6,000.

No discussion; no objections, motion carried.

Council on Medical Economics

FLOYD K. HURT, Chairman

1. COMMITTEE ON ADVISORY TO BLUE SHIELD

The full Committee has met twice since the last meeting of the House of Delegates. The first meeting was on September 16, 1962, and the second on March 31, 1963. The following actions were taken.

At least one and usually two members of your Committee have been present at each meeting of the Blue

Shield Board of Directors.

A number of members thought that the main functions of the Committee have been relegated to other committees and questioned its present effectiveness. It was requested that the Board of Governors re-study the Committee's function and purpose.

COMMITTEE ON COMMERCIAL HEALTH INSURANCE

The Committee met in informal joint session with representatives of the Florida Health Insurance Council on January 12, 1963, at which time there was full discussion of insurance review committee activities at the local county medical society level. Results of a survey made during the year indicate that 21 county societies have established an active insurance review committee or a committee that performs, in addition to other activities, the duties of an insurance review committee. The Association's Board of Governors endorsed and approved the action of the Committee to prepare a handbook to assist insurance review committees of component county medical societies. This guide is near completion and is expected to be ready for printing and distribution in the near future.

Whereas, the Florida Commission for the Cost of Medical Care has approved in principle the establishment of utilization committees in hospitals throughout the

State of Florida; therefore, be it RESOLVED, That the House of Delegates of the Florida Medical Association approve this recommendation of the Florida Commission for the Cost of Medical Care, and request its component county medical societies to recommend the establishment of utilization committees and assist in the establishment of these committees.

3. COMMITTEE ON FEE SCHEDULES

This is a continuing report of the activities of the Committee on Fee Schedules as carried along from our last report.

The main activities of this Committee have been centered around two problems this year. One has been the development of a Florida Relative Value Study as directed by the House of Delegates previously. Second has been to resolve the problems related to the Workmen's Compensation Fee Schedule of the Florida Industrial Commission.

Since there was much misunderstanding within the profession itself concerning fee schedules, it was thought that we had to resolve our internal problems before we could be at all effective outside of the profession. The development of the Florida Relative Value Studies was the focal point for resolving many of our internal problems concerning fee schedules. The Committee on Fee Schedules had a meeting on July 15, 1962, following the meeting of the Council on Specialty Medicine, which was held on July 14. The entire Relative Value Studies was gone over and the recommendations of the Specialty Council taken into consideration and the final problems resolved. This meeting was long and arduous, but was extremely fruitful. Ability to agree on many controversial problems at this meeting was the result of many individual informal conferences among ourselves, excellent staff work by Mr. James of Association headquarters, and much correspondence. As a result of this meeting our Relative Value Studies in preliminary form was developed. This was then authorized for printing, after the proof copy was checked by the Committee and by the Council on Specialty Medicine. The Relative Value Studies was finally completely approved, and on November 9, 1962, we printed our revised Florida Relative Value Studies for 1962. This has been a most unifying experience. Our objectives have emerged clearly; we are all in a much better frame of mind and we have made great progress.

After our Relative Value Studies was printed, we then undertook the problem of our Workmen's Compensation Fee Schedule. At the Committee meeting on July 15, 1962, the decision was made to request the Florida Industrial Commission to use as a guide the Florida Relative Value Studies for 1962. This meant that in principle those items applicable could be used in developing code numbers and descriptions for Workmen's Compensation schedules, In addition, it was agreed that the Florida Industrial Commission would be requested to develop a Medical Advisory Committee from the ranks of the Florida Medical Association to insure proper working of any further fee schedule. It was also agreed that we would request the Florida Industrial Commission to publish a no-printed-fee schedule based much on our experience with the Medicare

We would also request the Florida Industrial Commission to develop, with the help of the Medical Advisory Committee, a set of guides which neither set minimum nor maximum fees for use by the Commission and the Medical Advisory Committee. The letter therefore was sent to the Florida Industrial Commission on July 15 outlining these proposals. These proposals have been under consideration since that time by the Industrial Commission, and we believe that it is favorably disposed toward accepting them. A telephone conference of the Committee on Fee Schedules along with officers of the Florida Medical Association was held on February 18, 1963. A presentation by the Chairman to the Council on Specialty Medicine to bring the members up to date was held on February 16, 1963, previous to the telephone conference. It is believed that all segments of medical practice in Florida through the medium of their leadership have now been informed. It is our fervent hope that before our next Annual Meeting this new fee schedule utilizing no fixed fees will be in operation. If the Florida

Industrial Commission does not accept this, we *must* be prepared to stay unified and be prepared for trouble.

One hope is that if and when the new Workmen's Compensation Fee Schedule is adopted, proper means of communication may be established so that each member of the Florida Medical Association will do his utmost to cooperate with this program and make it successful. There is much more at stake in organized medicine than merely the Workmen's Compensation fee problem, and our utmost cooperation on this one problem will make our coordinated efforts easier in other problems.

4. COMMITTEE ON INDUSTRIAL MEDICINE

The Chairman of this Committee, who is also a member of the Committee on Fee Schedules, has met with the Committee on Fee Schedules at numerous meetings negotiating for a more equitable Workmen's Compensation Fee Schedule. Much has been accomplished, and it is anticipated that existing inequities will be corrected in the near future.

The Committee was represented at the Workmen's Compensation Educational Conference at Palm Beach, on October 24, 25, and 26, 1962, and a report of the conference was published in the April 1963 Journal of the Florida Medical Association.

Also the Committee was represented at the Regional Meeting of State Chairmen of Committees on Occupational Health with the Council on Occupational Health, American Medical Association, at Birmingham, Ala., on February 24, 1963.

At the conference in Birmingham very interesting discussions were held on a number of subjects, notably:

- (1) The physician's role in encouraging rehabilitation rather than indemnification.
- (2) Means of increasing the teaching of occupational medicine in medical schools.

It was agreed that the Medical College of Alabama with its department and full time professor of occupational medicine has the best undergraduate program. There are several available postgraduate courses in industrial medicine, but other schools relegate this phase of medicine to one or two lectures in the public health department. It was recommended that more articles on occupational medicine be contributed to student magazines.

(3) Means of encouraging physicians in occupational medicine to become more active in their constituent medical society. Many sections can attest to the fact that industrial physicians, both full time and part time, are welcomed with open arms as proved by the many instances of their being elected to important offices and these men are proving to be great assets to organized medicine. We were reminded that occupational medicine is public health under the private enterprise system, and we need its standards in our state medical associations.

5. MEDICARE MEDIATION COMMITTEE

This report is made on a calendar year basis to coincide with the accounting procedures of the fiscal administrator, Blue Shield.

During the year six meetings were held, four in Jacksonville, one in Miami Beach and one in Gainesville. Attendance at all meetings was excellent.

Blue Shield paid 12,180 claims to physicians for a total of \$1,025,525, an increase of \$125,833 over the amount paid in 1961. Of these claims, 543 (4.4 per cent) were referred to the state and county committees for consideration. The number of physicians participating was 1,847, or 20 more than 1961.

The county Medicare committees are again commended for their cooperation and assistance. Their ability to investigate records, talk with the physicians involved, and make recommendations to the state committee has been of inestimable value.

The present Medicare contract expired on April 30,

1963 and has been extended for one month. Negotiations are now in process for a new contract.

6. COMMITTEE ON MEMBERS INSURANCE

The Committee did not meet formally during the year; however, the Chairman held several conferences with representatives of Marsh & McLennan, Inc., administrator for the Association's sponsored and approved plans.

Professional Liability Insurance: Effective January 1, 1963, the professional liability carrier was changed from Carolina Casualty to EMPLOYERS' FIRE INSURANCE COMPANY, which has assets of approximately \$47 million and is a member of the Employer's Group of Insurance Companies, whose combined assets are approximately \$167 million. Best Insurance Guide rates this company "A Plus," which is the highest policy holder rating this authoritative source gives any insurance company.

The broadened policy form eliminates previous exclusions with respect to alcohol, narcotics, and criminal acts, and the only remaining policy exclusions are: 1) To any use of x-ray apparatus for therapeutic treatment unless such use is specifically declared in this policy. 2) To liability of the insured as proprietor, superintendent or executive officer of any hospital, sanitarium, clinic with bed and board facilities, laboratory, or business enterprise.

With the broadening of this policy there is a continuation of the previous rates which are 15 per cent below those offered by most companies, and also the usual 20 per cent partnership surcharge, where all partners are covered, has heen eliminated.

Currently, a filing is pending before the Insurance Commission of the State of Florida requesting reclassification and revision of rates. The proposed reclassification and revision plan is supposedly to achieve a more equitable distribution of insurance cost among physicians. The Florida Medical Association is on record with the Insurance Commission as objecting to the proposed reclassification plan until such time as full and adequate explanation as to the effect of the filing has been presented and discussed by the Council on Specialty Medicine.

The other benefit plans, which include: 1) Disability Income, 2) Catastrophic Hospital-Nurse Expense, 3) Office Overhead Expense, and 4) Accidental Death and Dismemberment, are currently being reviewed by Marsh & McLennan, Inc., and the concerned insurance companies. The purpose of the review is to obtain an over-all evaluation to determine needed change of benefits, etc., regarding the program to keep them competitive and actuarially sound.

Recommendations:

The Council on Medical Economics submits the following Committee recommendations:

1. Advisory Committee to Blue Shield:

Four proposed supplementary medical care riders were approved. These would provide coverage for (a) additional in-hospital medical care, (b) consultation services, (c) additional pediatric services, and (d) prolonged detention. It was pointed out that these would provide supplemental coverage in the event the subscriber wants it and would be at an additional premium.

The Committee recommended that the Board of Directors of Blue Shield investigate the possibility of the corporations of Blue Cross and Blue Shield cooperating financially in the underwriting of major medical policies.

The Committee recommended that the members of the Florida Medical Association continue to support the function and activity of Blue Shield of Florida.

2. Committee on Commercial Health Insurance:

The Committee again recommends that continued attention be directed toward further improvement of liaison between organized medicine and the commercial health insurance industry. Of major concern to the Committee is the importance of encouraging and assisting in the establishment of insurance review committees in all component county medical societies.

3. Committee on Fee Schedules:

There are no recommendations at the present time since the Committee is simply following the dictates of the House of Delegates and the Council on Specialty Medicine.

4. Committee on Industrial Medicine:

After approval of the pending new schedule of average fees to be used as a guide for Workmen's Compensation cases, it will be more important than ever that a medical board be appointed to work with the medical advisor, (Dr. Thomas J. Bixler), Florida Industrial Commission. This board would act in an advisory capacity to the Florida Industrial Commission to aid in solving problems pertaining to fees in Workmen's Compensation cases.

It is recommended that the name of this Committee be changed from that of Committee on Industrial Medicine to Committee on Occupational Health to conform to

the American Medical Association nomenclature.

5. Medicare Mediation Commission:

Again it is the recommendation of the Medicare Mediation Committee that the Florida Medical Association continue to cooperate in caring for the medical needs of the dependents of the Armed Services and extend its contract with the Office for Dependents' Medical Care.

6. Committee on Members Insurance:

The resolution of the Dade County Medical Association concerning a basic medical and hospitalization policy for assigned risks. The Committee concurs with the expressions of the State Insurance Commission which are: No parallel exists between vehicle liability insurance and accident and health insurance. Vehicle liability coverage is of involuntary nature intended primarily for the protection against both bodily and personal property damage of those other than the insured. Medical and hospitalization insurance is designed solely as protection for the insured against personal expense incurred due to sickness. Existence of accident and health insurance depends entirely on the preservation of the cherished concept of competitive free enterprise, and for this reason no level of government should exercise direction regarding mandatory coverage or its availability by insurance companies, both commercial and prepayment plans.

2. Resolution 62-3 Malpractice and Negligence Suits offered by the St. Johns County Medical Society. The Committee is presently concerned with the participation by members in the Association-sponsored program of professional liability (malpractice) insurance. Of prime concern is the claim experience which will be developed under this program through future growth. Until such time as actual claim experience is developed which will reflect a pattern for malpractice and negligence suits, the Committee believes that establishment of a committee to study and make

recommendations in this area may be somewhat

premature at this time.

"The report of the Council on Special Activities is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Special Activities

W. DEAN STEWARD, Chairman

Council:

The Committee reports for this Council are brief and to the point.

The Council on Special Activities wishes to thank the respective Committees, their Chairmen and members for agreeing to serve during the past year and for their contributions toward making this a successful year for our organization.

COMMITTEES:

1. Committee on Advisory to Woman's Auxiliary.

The Woman's Auxiliary to the Florida Medical Association has been very active this year. The Advisory Committee met with the Auxiliary at its fall board meeting in St. Augustine, at which time the Chairman discussed the medicare problem as related to the Kerr-Mills Bill and the President's social security program. At this same meeting Dr. Edward Jelks gave a very entertaining and enlightening address.

On numerous occasions problems have been discussed and settled by telephone conversations with the Auxiliary

officers.

Recommendations:

That future Advisory Committees should hold themselves in complete readiness to cooperate willingly and enthusiastically with the Auxiliary officers, for the Auxiliary is considered to be a valuable asset to the Florida Medical Association.

2. Committee on AMA House of Delegates.

The Florida Medical Association is now represented by five delegates to the American Medical Association. All delegates were in attendance and took active part in the proceedings at the June 1962 meeting held in Chicago and at the Los Angeles clinical meeting held in November 1962.

It was a distinct honor to the physicians of Florida to see our own Dr. Edward R. Annis become the President-Elect of the American Medical Association at the June meeting in Chicago.

"A portion of the Board of Governors' Report, page 33 in the Handbook, the first paragraph, headed Blue Shield, was referred to Reference Committee No. IV. It is our recommendation that this be amended by deleting Item 2.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

BLUE SHIELD.—The Board unanimously approved the following recommendations: 1) To request the Blue Shield Board of Directors not to entertain recommendations of specialty groups until they have been considered and presented by the Committee of 17 to the Blue Shield Board of Directors; 2) That in recognition of the problems Blue Shield of Florida has in working with national employers, approval in principle be given to participation of Blue Shield of Florida in national contracts on an indemnity basis only, utilizing the Professional Services Index of the National Association of Blue Shield Plans as a basis for fee schedules.

"Resolution 63-1, Voluntary Health Insurance for Aged, by the Orange County Medical Society is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 63-1

Voluntary Health Insurance for Aged Orange County Medical Society

Whereas, Health insurance coverage of all citizens who have reached age 65 is a desirable objective; and

Whereas, This coverage should be extended on a voluntary basis rather than on a compulsory basis in a manner consistent with the dignity and independence of each individual; therefore, be it

RESOLVED, That the Orange County Medical Society favors the enactment by the Congress of the United States of an Act amending the Internal Revenue Code to provide the following:

1. Tax incentives for those citizens who have reached 65 and are able to provide voluntary health in-

surance for themselves.

2. Tax incentives for relatives or former employers who are able to provide such insurance for them,

3. Direct Government assistance for those citizens who have reached age 65, and are otherwise unable to obtain such protection, to enable them to purchase health insurance of their own choice, such portion of the Act to be administered in cooperation with each of the several States, and

 Requirement that such insurance be guaranteed renewable, subject to certain minimum standards.

and include catastrophic coverage;

and further be it

RESOLVED, That this resolution be forwarded to the Delegates to the American Medical Association of the Florida Medical Association recommending that it or one of similar intent be presented to the House of Delegates of the American Medical Association at their Clinical Meeting and that copies of this resolution be sent to every County Society in the State of Florida and to every State Medical Association.

"Resolution 63-3, To Restrict the Florida Medical Association from Entering into Contracts with Agencies, Firms or Persons Which Will Establish Fees Binding Upon Its Members, by the Lake County Medical Society, is disapproved.

"Mr. Speaker, I move that this resolution be not approved and not published in The Journal."

No discussion: no objections, motion carried.

"Resolution 63-5. Support for Vocational Rehabilitation, by the Duval County Medical Society, and the amendment to this resolution which was read in the First House of Delegates were carefully considered. The Reference Committee recommends adoption of the resolution as printed in the Handbook, with disapproval of the amendment.

"Mr. Speaker. I move the adoption of this portion of the report as printed in the Handbook."

Dr. Manson, of Duval: "I wish to speak for the amendment and its adoption. The amendment requests that members of the Medical Advisory Committee of Vocational Rehabilitation be appointed by the Florida Medical Association and approved by the Governor of Florida. By voting against this, we in F.M.A. do not wish a voice in governmental agencies, or we want control by

government with perhaps cultist group participation. The Attorney General's office gave this opinion to Mr. Andrews, who is Director of Vocational Rehabilitation, on his question regarding Vocational Rehabilitation's obligation to osteopaths, and I quote: 'There is no law or regulation which prohibits the use of osteopaths in this program.' The Attorney General explained that a public agency could not discriminate against a licensed osteopath. The opinion was expressed that they could not specifically debar certain practitioners that are not included by law. This may raise also the question of naturopaths and chiropractors. The Director of Vocational Rehabilitation at its last meeting said, and again I quote: 'That members of the Medical Advisory Committee, nominated by the Florida Medical Association and appointed by the Governor, would meet with the approval of Vocational Rehabilitation.'

"Gentlemen, are we going to let certain vested interests in Vocational Rehabilitation lead us more quickly into socialism and cultist association? You have just reaffirmed your stand against osteopathy, and in resolution 63-14 recommended F.M.A. representation on state hospital boards; why not Florida Medical Association representation on Vocational Rehabilitation?

"I move, Mr. Speaker, to amend the motion of the Reference Committee to include the amendment as proposed by the Duval County Medical Society."

Dr. Fred A. Butler, Council on Specialty Medicine and also a member of Reference Committee No. IV: "I appreciate the intent of Dr. Manson's amendment, but I do not believe it is necessary in actuality. This advisory committee has rarely had anyone on it but doctors, and once in my memory, a dentist, and once a hospital administrator, but for many years now, doctors. It is comprised of members of the Florida Medical Association. Usually there are one or two past presidents on this committee; there are at the present time three general practitioners. Mr. Andrews particularly desires to have a good spread of specialists throughout the specialists' groups in Florida, as well as a geographic spread. and I believe this has been accomplished. However, if this amendment is supported in the House of Delegates, I would like to introduce an additional amendment, that the members of this committee as nominated to the Governor by the Florida Medical Association be comprised of the 15

specialty groups represented on the Council on Specialty Medicine, and give Mr. Andrews adequate numbers of people in each specialty, so that he can choose people who not only represent the specialties, but those who have had some experience, and most important, some interest in Vocational Rehabilitation."

Dr. Zellner: "I agree with Dr. Manson's feeling, but I think this amendment would be very ill-advised, for this reason. There is not a single state agency which has a medical advisory committee, which has to seek this information from the Florida Medical Association. I can assure you that irrespective of the action taken by this House, it will amount to nothing. Governors are jealous of their prerogative to appoint whom they please. We have had excellent rapport with recent administrations, but I do not think we can ask the Governors to give up their constitutional prerogatives. It seems to me that the suggestion of the Reference Committee is best."

Dr. Meredith Mallory, of Orange: "I suppose I have been connected with Vocational Rehabilitation longer than any other member. Your Board of Governors, with all due respect, could not pick any better advisory committees than they have had all these 15 or 16 years. We have had past presidents of the Florida Medical Association, one president of the American Medical Association; in fact, we have had the best men in the Florida Medical Association, with all of the specialties represented. If you have the best men in the F.M.A. now, why change it?"

The motion to amend the Reference Committee report was defeated.

Dr. Evans: "Before voting on the main motion, it has been pointed out that there is a technical error in the resolution as printed in the Handbook. The first Resolved states: 'Resolved that the Duval County Medical Society . . .', should be changed to read, 'Resolved that the Florida Medical Association. . . .''

The motion carried.

Resolution 63-5

Support for Vocational Rehabilitation Duval County Medical Society

Whereas, Unemployable persons who are indigent, or semi-indigent, are rendered employable through judicious use of the Vocational Rehabilitation agency; and

Whereas, Vocational Rehabilitation represents one of the soundest public investments in indigent unemployable persons; and Whereas, A high percentage of indigents are rehabilitated through this Agency; and

Whereas, State funds allocated to this Agency have in recent years not been of such a magnitude as to take advantage of allocated federal matching funds; and

Whereas, Expenditure of these funds is on the basis of need, and control rests at the local level, and as such falls within the AMA's philosophy of federal-state cooperation; be it

RESOLVED, That the Florida Medical Association support fully the work of Vocational Rehabilitation; be it further

RESOLVED, That the Florida Medical Association support Vocational Rehabilitation and recommend to the legislature that state funds be appropriated so as to take advantage of federal funds so allocated.

Dr. Cooney: "Resolution 63-6, Vocational Rehabilitation, by the Marion County Medical Society, we recommend be not approved and not published in The Journal."

"Mr. Speaker, I move that this resolution be not approved."

Dr. Henry L. Harrell, of Marion: "I move that we delete the recommendation that this not be published in The Journal. We do not mind being governed by the majority rule, but I think the minority opinion should show."

The amendment carried.

The motion as amended carried.

NOT APPROVED

Resolution 63-6 Vocational Rehabilitation Marion County Medical Society

Whereas, The physicians of Florida recognize the Federal Vocational Rehabilitation program as excellent and worthy except that it allows for bureaucratic control of medicine; and

Whereas, This objectionable feature can be removed in a manner to make the program less expensive to the taxpayer and more effective in the patients' rehabilitation; be it therefore

RESOLVED, That if a patient is found by investigation of the district representative of the Vocational Rehabilitation program to be sufficiently disabled as to require attempt at rehabilitation, the physicians of Florida agree to do necessary examinations and definitive treatment at no immediate cost but with the stipulation that if and when the patient recovers his ability to make a living the physicians involved be reimbursed by the patient at a fee determined by agreement between the patient and the physician; be it further

RESOLVED, That the patient be allowed his free choice of physician; be it further

RESOLVED, That the Florida delegates to the AMA be instructed to submit the intent of this resolution to the House of Delegates of the American Medical Association.

"Resolution 63-8 on the Veterans Administration was withdrawn by the Putnam County Medical Society in favor of Resolution 63-13, which contains the same subject matter. "In Resolution 63-9, Crippled Children's Commission, by the Seminole County Medical Society, we recommend that the word 'some' be inserted after 'Whereas' in the first line of the resolution, also, that the word 'some' be inserted preceding the word 'referring' in the first numbered paragraph of this resolution, so that the preamble will read: 'Whereas, some referring physicians have expressed dissatisfaction. . .,' and the first numbered paragraph will read: 1. Some referring physicians are not kept abreast. . . .'

"Mr. Speaker, I move the adoption of this resolution as corrected."

No discussion; no objections, motion carried.

Resolution 63-9

Crippled Children's Commission Seminole County Medical Society

Whereas, Some referring physicians have expressed dissatisfaction with the lack of coordination and cooperation of the Various Florida Crippled Children's Commission Clinics, in that:

 Some referring physicians are not kept abreast of therapeutic plans and treatment rendered in the

 This places the referring physician in an awkward position in dealing with the parents and managing complications and problems arising from treatment;

be it hereby RESOLVED, That:

 Reports of all visits to the Crippled Children's Clinics be furnished to the referring physician as soon as possible;

As much responsibility as possible in the care of the patients be delegated to the referring physician.

"Resolution 63-10, Tumor Clinics, by the Seminole County Medical Society, is not approved. The Committee is in sympathy with the authors of this resolution and believes that this could best be remedied by the establishment of a tumor clinic in Seminole County.

"Mr. Speaker, I move that this resolution be not approved and not published in The Journal."

No discussion; no objections, motion carried.

"Resolution 63-11, Tumor Clinics, by the Jackson-Calhoun County Medical Society is not approved. This community, the Committee feels, like some other areas of the state, is probably now ready for the establishment of its own tumor clinic.

"Mr. Speaker, I move that this resolution be not approved and not published in The Journal."

No discussion; no objections, motion carried.

"Resolution 63-13, Veterans Administration, by the Jackson-Calhoun County Medical Society, is approved as printed in the Handbook. "Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 63-13

Veterans Administration Jackson-Calhoun County Medical Society

Whereas, It is the present intention of the Veterans Administration to construct approximately 1,400 new hospital beds in the State of Florida; and

Whereas, No need for these beds for the care of Veterans with service-connected disabilities has been shown; and

Whereas, Approximately 90% of the present beds in use are utilized primarily for the care of non-service-connected disabilities of allegedly indigent veterans, although no appropriate check of their indigency is made; be it therefore

RESOLVED, By the Florida Medical Association that it deplores the construction of any new beds until need is shown; that it opposes the Veterans Administration care of non-service-connected disabilities, particularly when the veteran is not medically indigent; and that the Florida Medical Association recommends that more efficient utilization of present beds, with appropriately shorter hospitalization time, would solve any bed shortage problem that now exists or might exist in the foreseeable future; be it further

RESOLVED, That this organization can not support or condone the expenditure of public money for the construction and maintenance of such expensive facilities when the need is neither apparent nor predictable.

"Resolution 63-17, Blue Shield, by the Orange County Medical Society, was included in your Delegates' packets and is approved as written.

"Mr. Speaker, I move the adoption of this resolution."

No discussion; no objections, motion carried.

Resolution 63-17

Blue Shield Orange County Medical Society

Whereas, The Orange County Medical Society believes that Blue Shield of Florida has the ability to provide the best type of prepaid medical care protection for the cifizens of Florida; and

Whereas, It is essential that doctors retain control of the practice of medicine, and not lose it to the government, or any other non-medical party; therefore, be it

RESOLVED, That the Orange County Medical Society recommends to the Florida Medical Association that Blue Shield of Florida be maintained and strengthened in every way possible; and that individual doctors and county medical societies give this Plan their wholehearted cooperation and support; be it further

RESOLVED, That the resolution be submitted to the House of Delegates of the Florida Medical Association meeting for approval in session at Hollywood, May 1963.

"Resolution 63-21, Advisory Committee to Blue Shield, or the Committee of 17, presented by Dr. W. Dean Steward, is approved as read to the First House of Delegates.

"Mr. Speaker, I move the adoption of this resolution."

No discussion; no objections, motion carried.

Resolution 63-21

Blue Shield

WHEREAS the Advisory Committee to Blue Shield has served a very useful purpose since its very beginning in creating an excellent working relationship between the Florida Medical Association and Blue Shield of Florida, and

WHEREAS each chairman of this Advisory Committee to Blue Shield, Dr. Henry J. Babers, Jr., Dr. Robert E. Zellner, Dr. Ralph M. Overstreet and Dr. Carl McLemore, has served with dignity and a dedication to the ideals of medicine, and WHEREAS the "Committee of 17" in its deliberations

WHEREAS the "Committee of 17" in its deliberations has created an excellent liaison between the Florida Medical Association and Blue Shield of Florida, therefore

BE IS RESOLVED that the Board of Directors of Blue Shield of Florida requests the House of Delegates of the Florida Medical Association to strengthen its statement of purpose which will guide the Committee of 17 and give every possible aid to this committee as it works to develop close coordination between the medical profession in Florida and Blue Shield, its economic arm.

"Resolution 63-24 on the Liberty Amendment, presented by Walter W. Sackett Jr. The Committee, on the advice of Mr. Harry T. Gray, Legal Counsel for the Florida Medical Association, took no action on this resolution. It was the opinion of the Committee that this resolution on the Liberty Amendment should be referred to the Florida Medical Committee for Better Government for action."

Dr. Evans: "The fact that the Reference Committee took no action on a resolution that had been presented to the House of Delegates, in my opinion, does neither defeat it nor pass it, I think this matter should come before the House as unrecommended either way."

Dr. Cooney: "It was the opinion of legal counsel that this matter does not come within the scope of the Florida Medical Association's By-Laws. Therefore, I move that the resolution on the Liberty Amendment be referred to the Florida Medical Committee for Better Government for its action."

Motion seconded.

Dr. Walter W. Sackett Jr., of Dade: "I would like to appeal this ruling of the Reference Committee and urge consideration of this resolution on the floor today. We are a business league and, as such, we can take action on this. This is within our purview.

"I move that we consider this resolution on the floor today."

Dr. Zellner: "I rise to a point of order. The Florida Medical Association has received advice from its legal counsel that it should not take up this subject. The issue involved is not the merit of the Liberty Amendment; the issue is whether we can become involved in this. There is a question of legality, whether we would be violating our Charter. I put the question, therefore, as to whether further discussion of this is in order?"

Dr. Evans: "This is a question of order, whether this should be taken up or not and I think this is a question for the Chair to decide. I think this should be submitted to the House—not the merits of the amendment—but whether or not the House should consider this question."

Dr. Sackett restated the motion — that the House vote on whether or not the subject should be considered.

Seconded by Dr. Zellner.

Dr. Charles R. Sias, of Orange, asked if it would be possible to hear Mr. Gray's opinion on this matter.

Dr. Evans: "As you know, a non-member may have the privilege of the floor only on the unanimous consent of the House."

Dr. Alpheus T. Kennedy, of Escambia, moved that the House go into executive session if Mr. Gray were to speak.

Motion was seconded and was defeated. -

Mr. Gray was given the privilege of the floor. Mr. Gray: "I use as my text the remarks of your first speaker, the attorney, who so ably showed that the Supreme Court of the United States is getting out of bounds and out of its field in running the country. This society is organized to operate in a particular field, and that field is not general legislation, nor is it the regulation of all the business in the United States. If you get in that field, I think as a lawyer and as your friend, you get into criticism and trouble. I have no objection to this doctor supporting this Liberty Amendment, but he should do it individually. If he wants to go to his Chamber of Commerce and get their support, it is in their field. If he wants to go to a civic club, he can do it. I am not opposed to the action of individuals on anything, but when you doctors get out of the field of medicine and get into the fields of politics and general legislation, then you are outside your field. I think that if you stick to what Dr. Zellner said, the cementing of relations between doctors and the public, rather than get into the field of business and constitutional amendments, you will go along much better."

Dr. William H. Keeler III, of Pinellas: "I would like to call upon our representatives to the

American Medical Association to perhaps clarify this a little bit for us. It is my understanding that this amendment is going to be discussed by the A.M.A., and I think it is important to us that our Delegates know the feeling of the House of Delegates before voting at the A.M.A. convention."

Dr. Reuben B. Chrisman Jr., A.M.A. Delegate: "As you know, it has been brought to the A.M.A. and the reference committee recommended that it be referred to the Council on Legislation. They have considered it three times and turned it down."

Dr. Sackett: "I sat in the A.M.A. reference committee in Los Angeles last year for several hours. One of the reasons that action was deferred was that they wanted the feeling of the various states. How can they vote on this when it comes to the floor if our Delegates are not instructed? I would further say, I think Mr. Gray has failed to show where in our Charter we cannot consider such a matter. Reading from Article II: 'To guard and foster their material interests,' speaking for doctors, and further down: 'to carry out these objects of the corporation as a business league,' and I am sure under this Charter, we can discuss this resolution."

Dr. Cook asked whether the A.M.A. turned this down because the members were against it or because they felt it was outside their purview.

Dr. Chrisman: "They first turned it down on the thinking that it was not within the purview of the American Medical Association. However, it was then referred to the Council on Legislation. The Council, on three occasions since the Los Angeles meeting last November, has considered the Liberty Amendment and is recommending at the Atlantic City meeting in June that it be not approved by the American Medical Association."

The Chair called for a voice vote which was indecisive.

By a standing vote, motion carried 81 to 61. Dr. Mosley, of Duval: "It is now 12:40. It is obvious from what has gone before that this is going to take much time. We have to have our election of officers. I move that we limit debate to stop and have the election of officers at five minutes before one o'clock."

No discussion; no objections, motion carried.

Dr. Cook, of Jackson-Calhoun: "Although I am personally in favor of the Liberty Amendment, this is an amendment to the Constitution of the United States, and many of the Delegates have

not read the amendment, or investigated the figures and what it would mean. I do not think with the limited time we have available here, we can possibly consider an amendment to the Constitution of the United States.

"I move that we table this discussion and it be referred to the Board of Governors for recommendations."

Motion seconded and carried.

Dr. Cooney moved adoption of the entire report as amended.

No discussion; no objections, motion carried.

Dr. Cooney thanked the members of his Committee: Drs. Jack Q. Cleveland, Fred A. Butler, Jack A. MaCris, Ernest R. Bourkard and Burns A. Dobbins Jr., Advisory.

Nominations for President-Elect were called for by the Speaker, Dr. Peek.

Dr. Jere W. Annis, of Polk: "Twelve years ago in this same city, I nominated Sam Day for the position of Secretary-Treasurer of the Florida Medical Association. You elected him, and have re-elected him every year since that time. Inasmuch as I got him into this, it seems only fair that I get him out of it. This I propose to do today by nominating him for President-Elect.

"No man has contributed more to our organization than Sam Day. No man has identified himself with its every detail as much as this Alabama boy who came to settle as a surgeon in Jackson-ville. No man is in possession of as many pertinent facts, both of the past and of the present, and no one is as well qualified to direct our course in the years ahead. It is unnecessary for me to give you his curriculum vitae—you do not need the vital statistics—you know the man.

"At this time, Mr. Speaker, I nominate Dr. Samuel M. Day for the office of President-Elect of the Florida Medical Association."

Dr. Hugh A. Carithers, of Duval: "I think it is perfectly proper and just that we should yield to Jere Annis in nominating one of our favorite sons, Mr. Organized Medicine, himself, Sam Day. We could talk at length about Sam's qualifications; you all know them, but I would like to second the nomination of Dr. Sam Day for President-Elect."

Dr. Alpheus T. Kennedy, of Escambia: "Escambia would like to present for President-Elect a man who can easily and quickly seek out the heart of any given problem and objectively look not only at both sides, but all sides. This man is well known to all of us. Escambia unanimously

endorses and takes great pride in seconding the nomination of Sam M. Day."

As there were no other nominations, the Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Day.

The Speaker asked Dr. Day to come to the podium.

Dr. Day: "Dr. Annis, Members of our Association, I thank you for this honor. I am reminded of what happened with one of my boys a few years ago, when he was just a little tot and was helping me with some yard work. When he finished, he said: 'Daddy, are you going to pay me for this, or are you going to 'preschishate' it?' I assured him that I would 'preschishate' it, just as I assure you I appreciate being elected to this office. It is an honor. I thank you, too, for the cooperation and aid that you and many others in our Association have given me through the years that I have served as Secretary. The staff of the Florida Medical Association have been as cooperative and as able as any staff could be. I would be remiss if I did not recognize Dr. Robert McIver, who preceded me in the office of Secretary and in the office of President, and who so ably helped me in the early years of my office. Dr. McIver, will you stand, please?"

Dr. McIver stood and was applauded by the assembly.

"That these are trying times with issues facing us which defy apathy is known to all of us. Our two able speakers of today have emphasized the gravity of the problems that confront our nation and the importance of our active participation in these matters.

"The A.M.A., in providing leadership, recently called the officers and representatives of our Association to Chicago to introduce 'Operation Hometown.' Comprehensive kits like these have been presented to county medical society presidents and will be brought to your local societies soon. This will help you to carry the fight at home, to help defeat measures which threaten the freedom of our people, the health of our patients and the stability and the future of our nation.

"I urge you to go home and help your society to let its voice be heard at the place where it is most effective.

"Again, I thank you."

The Speaker asked for nominations for the office of Vice President.

Dr. Cole, of Pinellas: "Mr. Speaker, Members of the House Delegates: Last year on the recommendations of your President, Dr. Zellner, the Board of Governors redefined the office of Vice President. It thus became more than just an honor given to a member of the F.M.A. Your Vice President now serves as a member of the Executive Committee, the Board of Governors, as a member of the Florida Medical Foundation, and represents the F.M.A. at various meetings in the absence of the President. This gives him the opportunity of becoming acquainted with the many facets of your state organization and enables him to participate in the formulation of policy which charts the course of the F.M.A. For these reasons, I feel that Dr. Phillip Hampton, of Hillsborough, with his background of service in the F.M.A. is particularly qualified for Vice President of the Association. Dr. Hampton has served as a member of the Board of Governors for the past four years and has done a magnificent job for us in his work and guidance in our legislative program. Those of us from the Sun Coast of Florida and many of your representatives from over the state who have had the privilege of working with Dr. Hampton have developed a sincere admiration for his zeal, his tenaciousness, his integrity and his ability. Mr. Speaker, I place in nomination for the office of Vice President, the name of Dr. Phillip Hampton of Hillsborough County."

Dr. Leo M. Wachtel, of Duval: "Mr. Speaker. Members of the House: It has been my privilege to know Phillip Hampton since college days and even better for the last four years as he has served on the Board of Governors. I can say without fear of contradiction that Phil Hampton has worked as hard as anyone in the Association for the Association and for you members, particularly in the field of legislation. I think it only right that he be permitted to continue to serve us on the Board as Vice President, and it gives me great pleasure to second his nomination."

Dr. Marshall E. Smith, of Hillsborough: "As Chairman of the Hillsborough delegation, it is my privilege to second the nomination of Phil Hampton. He has been active, as you know, in all aspects of organized medicine, including serving on committees for indigent care for the American Medical Association, and on the Florida Medical Association Council on Legislation and Public Agencies. It is a pleasure and privilege to second the nomination of Dr. Phillip Hampton."

As there were no other nominations, the Speak-

er asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Hampton.

Dr. Hampton was requested to come to the podium.

Dr. Evans took the Chair and asked for nominations for Speaker of the House.

Dr. Cook, of Jackson-Calhoun: "Mr. Chairman, a year ago I had the privilege of nominating Eugene Peek as the second speaker of our House of Delegates. I think we can live with him for another year, and I would like to nominate Eugene G. Peek Jr. to repeat himself."

As there were no other nominations, the Vice Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Peek.

Dr. Peek resumed the Chair and asked for nominations for Vice Speaker of the House.

Dr. Walter E. Murphree, of Alachua: "Mr. Speaker, for the third time I would like to nominate my candidate for this job and hope I will have the privilege for two more years following the precedent that is now being established. We are only in the third year of this, but precedents are being established and I hope they will continue. It is my pleasure to nominate to succeed himself as Vice Speaker of the House one who has so ably demonstrated his parliamentary ability this morning, Dr. Franklin J. Evans."

When there were no other nominations, the Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Evans.

The Speaker asked for nominations for the office of Secretary-Treasurer.

Dr. Edward Jelks, of Duval: "Mr. Speaker, Members of the House: We come to a real serious part of this program because to have someone to succeed Sam Day certainly is momentous. Two years before he went into the military service, Floyd Hurt practiced roentgenology in Florida. He served three years in the military service, and at his young age was made chairman of the roentgenological department of the station hospital at Boling Air Field. That was done, not because he could make such good films, but because he had the ability to lead the department. In 1946, he began two years' service as treasurer of his county medical society. In 1950 he was president of the Florida Radiological Society. In 1960, he was president of his county medical society. One of his most active interests in organized medicine has been Blue Shield. For nine years he has been on the Blue Shield Board and every one of the nine years that Board selected him as its treasurer. He has had assignments in the Florida Medical Association that have given him contact with the men and the problems of this wonderful organization. From 1959 to date, he has been Chairman of the Council on Medical Economics, from 1960 to date, Chairman of the Committee on Members' Insurance, from 1960 to 1963, Chairman of the Committee on Florida Investment Trust and he is also Chairman of the Joint Commission on the Cost of Medical Care. He has been reappointed and re-elected to these offices because his services have been pleasing and satisfactory to those concerned. It is with great pleasure that I present the name for Secretary-Treasurer of this organization of Floyd K. Hurt, of Duval County."

As there were no other nominations, the Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Hurt.

Dr. Hurt was asked to join the other officers on the podium.

The Secretary asked for nominations for Delegates to the American Medical Association, two delegates and two alternates for terms beginning January 1, 1964 and expiring December 31, 1965.

Dr. Charles R. Sias, of Orange: "It is my privilege on behalf of the entire membership of the Orange County Medical Society to renominate for the office of Delegate to the American Medical Association one of our most knowledgeable and dedicated men in this Association. I think a good example, right here this morning, was his testimony on Vocational Rehabilitation, and this was a true indication of his depth of understanding of this Association. There are very few men who have his knowledge of the Association. He has been off and on the Board of Governors for many years. His experience with the A.M.A. started when he was the only Delegate to the American Medical Association from the State of Florida. He has attended the meetings of the A.M.A. almost every year since then. Last year he served on one of the reference committees and I feel that his intimate knowledge and working relationship with delegates from all over the United States were a potent factor in the elections of Louis Orr and our Dr. Ed Annis as presidents of the American Medical Association.

"Mr. Speaker, I offer in nomination the name of Meredith Mallory, of Orlando."

Nomination was seconded by an unidentified Delegate from Dade County.

As there were no other nominations, the Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Mallory.

The Vice Speaker took the chair and asked for nominations for an Alternate Delegate to Dr. Mallory.

Dr. Henry L. Harrell, of Marion, nominated Dr. Eugene G. Peek Jr. to succeed himself.

As there were no other nominations, the Vice Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Peek.

The Speaker asked for nominations for another Delegate to the American Medical Association

Dr. Alpheus T. Kennedy, of Escambia: "We all know this man. We have heard him speak well and ably for many years in our Association.

"I place in nomination the name of Dr. Burns A. Dobbins Jr., of Fort Lauderdale."

Dr. Walter J. Glenn Jr., of Broward: "Broward County heartily supports the nomination of Burns Dobbins."

As there were no other nominations, the Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Dobbins.

The Speaker asked for nominations for Alternate Delegate for Dr. Dobbins.

Dr. Sackett, of Dade: "I would like to nominate that patient stand-in, who has been very loyal to us, Dr. Walter Murphree."

As there were no other nominations, the Speaker asked for a vote that nominations be closed and the Secretary cast a unanimous ballot for Dr. Murphree.

Dr. Peek: "We also at this time need to elect an Alternate Delegate to replace our late Frank D. Gray, who has been serving as Dr. Chrisman's alternate."

Dr. Charles Larsen Jr., of Polk: "I would like to place in nomination the name of Robert Zellner, who has served so ably as our President this year."

Dr. Miles W. Thomley, of Orange: "It is my honor to place in nomination the name of a man of demonstrated ability; he is a past president of this organization, is active in civic affairs and has made great contributions medically. We all know him well—Dr. Ralph Jack."

The Speaker asked for a standing vote as to whether the election of these two nominees should be by a show of hands or secret ballot. The House voted for a show of hands.

By a count of raised hands, Dr. Zellner was elected.

The Speaker called attention to the Board of Governors' nominations for the Committee on Membership and Discipline as shown on page 34 of the Handbook and asked for additional nominations from the floor.

As there were no other nominations, the Speaker called for a vote that nominations be closed and the Secretary cast a unanimous ballot for the following:

District William C. Roberts 1967 1 District 2 Raymond H. King 1967 District 6 Miles J. Bielek 1967 District Gordon H. McSwain 1967 George H. Garmany 1967 District 1967 District 11 Frank C. Bone

The Speaker asked Dr. Walter C. Jones and Dr. Hugh A. Carithers to escort the incoming President, Dr. Warren W. Quillian, to the rostrum.

Dr. Zellner: "Warren, two years ago when I wes elected President-Elect, I became aware of the almost proprietary interest that the Past Presidents of the Association have in this office. I couldn't understand it then, but I'do now. After one has put as much of himself into this Association as the presidency requires, he is very much interested in knowing it is passing on into able hands, and I am sure if I had had the pick of the whole Association, I could not have done as well as the Houses of Delegates. It is a real pleasure to present to you your personal gavel; I hope you wield it well and hard—but not on me."

Dr. Quillian: "In taking office as President, I do so with great humility, being well aware of the complex problems that have been called to our attention today, over and over—the problems that confront us today in Florida Medicine. But I am grateful for this honor and I hope that during the coming year I can repay by service a part of the great indebtedness that I owe to Medicine for the many good things that she has given to me.

"There are many pressures and trends that affect all of us both as citizens and physicians, but the true image of our profession in Florida will be created by the medical ability, the courtesy, the understanding and the sympathy of each individual physician here—definitely a 'do it yourself' proposition, as was emphasized in the presidential address on Thursday.

"In our organized groups such as the Florida Medical Association, establishment and maintenance of this good image depend on constructive policies which combine a devotion to high ideals and high medical standards and a concern for our fellow man. This we can accomplish with the mutual cooperation and the confidence of medicine with other groups. We have a wonderful organizational setup. We have a fine staff—an excellent staff — and an awareness of the job to be done. Successful results will be determined by the efforts of all of us. Challenges that confront the medical profession are as much in the field of politics and economics as in the field of scientific development, as was emphasized by Mr. Joseph Stetler earlier this week and again this morning reiterated by Senator Hruska and others. Leadership is needed, and I want to pay tribute to the magnificent job done by Dr. Zellner during the past year. He has been confronted with many difficult problems and has earned the admiration and respect of those with whom he has worked. Fortunately, during the coming year the Association will continue to enjoy the benefits of his mature counsel and experience, since he will remain as a member of the Board of Governors.

"It has been a source of comfort and strength to me personally to receive your expressions of eagerness and willingness to serve. Your response to the questionnaire concerning committee work have helped greatly in the selection of interested members to do various jobs. Obviously, everyone could not be used, but the information indicating your preferences has been filed and will be available for future utilization.

"I want to thank you for your good wishes. Now let us all work together for a progressive year in Florida organized medicine."

"Before closing, I would like to introduce two people who made it possible for me to accept this responsibility during the coming year. The first is Mrs. Quillian, known to many of you as Rosabelle, and whose love and loyalty have been and always will be a source of inspiration to me. The second, Dr. Jim Lancaster, my associate, has been very generous and unselfish during the last year while I was involved in Association affairs and necessarily away from the office a good deal and he has promised to do it again this year.

"My first duty as President is to present the Past President's button and the Past President's Certificate to Dr. Zellner, with the grateful appreciation of all of us for a job well done."

The House gave Dr. Zellner a standing ovation.

The Speaker asked Dr. Charles J. Collins and Dr. Duncan T. McEwan to escort Mrs. Zellner to the rostrum.

Dr. Quillian: "It is my privilege to present to Mrs. Zellner her husband's picture. It is evident that her unselfish help to him during the past year and her devotion have been in the true tradition of a loving wife as well as an auxiliary to organized medicine. I think during the year to come she will see and become more familiar with the original."

Dr. Quillian announced that the first post-convention Board meeting would be held in the Embassy Room immediately after adjournment.

Dr. Erasmus B. Hardee, of Indian River: "Mr. Speaker, I would like to make a suggestion to the executive management of the Florida Medical Association if it is not in conflict with our By-Laws. I suggest that a desk for the registration of Delegates be kept open at all times that the desk for members' registration is open. I ask this because I know of several Delegates who have made the attempt to get here for the first meeting of the House of Delegates, but for some reason could not make it. They find themselves entirely without status until this morning. Unless it is in conflict with the By-Laws, why should not a Delegate be able to register as a Delegate at any time during the meeting. I post that as a suggestion to the executive management."

Dr. Peek: "I would appreciate it if you would put that in letter form and send it to the Executive Committee."

The Speaker asked the House to stand while Dr. Homer L. Pearson Jr. gave the benediction.

Dr. Pearson: "Our Father, we thank Thee for this meeting. We thank Thee for its instruction and fellowship. Continue to be our guide; protect us, and give us sympathy and compassion. May Thy love and the grace of our Lord abide with us evermore. Amen."

Meeting was adjourned at 1:50 p.m.

President's Page

Let Us Go Forward

Deliver me not over unto the will of mine enemies: for false witnesses are risen up against me, and such as breathe out cruelty.

Ps. 27:12

Many of you attended the recent Eighty-Ninth Annual Meeting at Hollywood, enjoyed the program and had the opportunity to see old friends and make new ones. Now the Florida Medical Association is beginning another year. As your new President, I want to thank all of you for your confidence and trust. The responsibilities and obligations of this office are great, but I will do my best to fulfil them. Never in history has our profession been faced with so many problems vital to the practice of medicine. Everybody — the aging and the young, the rich and the poor, the acutely ill and the chronically ill — ought to have the privilege of selecting the physician of their choice. But threats are being made against this freedom of selection, as many of you are well aware.

The purpose of this column is to expound ideals, issues and policies for the best interests of Florida medicine. It is difficult to determine whether the words reach receptive ears. Current issues are discussed as they develop, and the reactions of your Executive Committee and Board of Governors are reported for your thoughtful consideration. Constructive comments will be appreciated. Let us use this medium for the discussion of problems which concern us all. Your President will be most grateful if you will communicate with him personally in reference to things you believe to be good for the Florida Medical Association. We need your help.

Let me make a special plea for more general participation and interest by our members in the affairs of organized medicine. As physicians, we are dependent upon all others in the profession and are obligated to assist other physicians. It is true that you may be accused of being a "medical politician." Various estimates have indicated that only 15 to 20 per cent of our membership are actively interested in the solution of those problems that beset us. Yet, thus far, this minority group has successfully withstood many attacks of those who are attempting to destroy our heritage in the practice of medicine as we have known it. We need the strength of our entire membership, working actively at all levels, as we have never needed it before. Please contribute your personal talents as an individual, and as a member of your county and state society, to all efforts made for preserving the freedom of the medical profession in our country. We have incurred obligations in providing the best medical care for everybody, regardless of age, race, creed or financial condition. As individuals, we hold the respect, admiration and affection of those whom we serve. Let us try to be worthy of this background.

Women wopineeran

J. Florida M.A./July, 1963



The Eighty-Ninth Annual Meeting

The Florida Medical Association Annual Meeting is many things to many people. To all, it is a chance to greet old friends, renew old acquaintances, and make new ones. To some it is an escape from practice and the home folks and a chance to "live it up." To others it is a time to become refreshed in things medical. To still others it is a time to carry out the necessary business of the Association. To many, or perhaps I should say, for most of the people attending, it is a combination of all these. The Eighty-Ninth Annual Meeting just concluded was essentially the same in these respects. Further remarks would seem appropriate though, and in the next few paragraphs I will try to give my impressions of this meeting, with possibly a few suggestions for future meetings thrown in.

To begin with, there was a new setting this year, the Diplomat Hotel, Hollywood-by-the-Sea. The accommodations were excellent, the meeting halls adequate for the most part, the exhibit hall spacious and of necessity en route to the Convention Hall. The help was most pleasant and courteous. The only disadvantage noted was the necessity of the membership being scattered in three buildings.

The technical exhibits were not as numerous as in past years, but those present had adequate displays and the attendants or detail men were most courteous. The use of a new "gimmick" with a drawing at the end of the scientific meeting contributed to a marked increase in the number of physicians visiting the technical booths. The booth personnel that I queried revealed that they were very much pleased with the interest shown by the physicians this year, in contrast to past years.

The scientific exhibits were varied. Most of them were interesting and well laid out. Without more than memory to rely on, I believe that more scientific exhibits were presented this year. The Committee on Archives had a very interesting exhibit, one that combined history and hobby. Other than this, the hobby exhibits were striking in their absence.

The general assemblies had most interesting speakers, but attendance, while better than it has been in the past, was not adequate. The specialty meetings were fairly well attended, as they usually are. Some of the programs that I was fortunate enough to attend were excellent. The House of Delegates operated smoothly, and reference committees were well attended and performed their functions of being good sounding boards.

One thing was more evident than ever this year. The Florida Medical Association is no longer a small society. It is now quite a large one and one which should offer much to its members at the Annual Meeting. It would appear that some changes should be worked out though, for the benefit of all concerned. The scientific assemblies are obviously not well attended, and might well be abolished. In their place, the use of sections or groupings of specialties could be tried, possibly with sessions up to one or two o'clock on Thursday, Friday, and Saturday, with the House of Delegates and references committee meetings in the afternoons when there would be no conflict with the scientific program. This plan would also allow some time for recreation which might increase attendance at the scientific sessions. The specialty groups could maintain their autonomy by furnishing speakers and by having their business sessions at breakfast or luncheon meetings. Such a method would allow the generalist or the physician interested in more than one specialty to attend many meetings during the three day session.

Too, I think the scientific exhibits should be encouraged. They are an excellent medium for teaching, and basically this is the purpose of the scientific portion of the program of the Annual Meeting.

D. DEAN STEWARD, M.D. ORLANDO

Our Relations With Osteopathy

Can doctors of medicine accept any second best system of practice or recognize as professional equals practitioners of any healing art which is not founded upon accepted truths and scientific facts? These questions were answered emphatically in the negative by the Board of Governors at its meeting on September 30 when it made this pronouncement: "The public looks to doctors of medicine, members of this Association, not only for medical care but also for accurate guidance on questions relating to health and medicine. Should this association or its individual members do anything to suggest its approval of cultism or cultists, or of the practice of unscientific medicine, not only would it be a disservice to the public, but it would also be a misuse of public trust." At the same time, it endorsed the policy adopted by the House of Delegates of the American Medical Association in June 1961: "There can never be an ethical relationship between a doctor of medicine and a cultist; that is one who does not practice a system of healing founded on a scientific basis."

The Board of Governors declared that the practice of cultism is not a matter of degree and any osteoptah who adheres to the original tenet of osteopathy is a cultist. It recognized that many, licensed as osteopaths, have veered away from its basic concept and are practicing a dilute type of medicine. It recommended that studies be made whereby those individuals, licensed as osteopaths, who desire to be recognized as practitioners of scientific medicine, can pursue courses of study and training through the facilities of medical schools and postgraduate medical education to obtain a degree of Doctor of Medicine, entitling them to be recognized by other doctors of medicine as professional colleagues. At present, there appears to be no demand in the state for these facilities, and the Board thought that until such a time does exist the door should be kept open and such proposals welcomed without the Association initiating any steps in this direction.

The House of Delegates of the American Medical Association recognized that problems pertaining to osteopathy are peculiar to the several states and recommended a declaration of prin-

Editor's Note: This editorial is reprinted from the January 1962 issue of The Journal at the request of the House of Delegates of the Florida Medical Association in session at Hollywood, May 19, 1963.

ciples at state levels. In like manner, the Board of Governors realizes different problems are present in the same state at county levels, depending upon the physician concentration, the availability of medical and hospital care, the quality of and economics involved in this care and the varying management and staff organizations of hospitals. For this reason, it was thought that no broad policy, covering all situations in the state, could be made at this time and it was recommended that component county societies of the Association establish policies regarding relationship of doctors of medicine with osteopaths within their own area. Complaints or problems which cannot be solved at local levels should be submitted through appropriate committees to the Association for consideration and action.

It was further stated by the Board that since the right to practice a healing art in a hospital is generally controlled and granted by boards composed of lay members, it shall not be considered an unethical act per se for a member of this Association to practice in a hospital required by law or its rules and regulations to admit cultists to practice, provided he does not enter into any professional relationship with them.

This, then, is a summary of principles and statement in regard to osteopathy adopted by the Board of Governors at its last meeting. Since the medical profession is dedicated to the best quality of medical care for all people, the Board had no option but to declare that until the present over-all situation throughout the state changes, our attitude withholding professional recognition of osteopaths as a group must be maintained. At the same time, this member of the Board had a definite impression that the wish to extend a helping hand to those who sincerely desire to spend the time and effort to qualify for the degree of Doctor of Medicine was genuine and void of any sense of arrogance. The degree of Doctor of Medicine does not confer upon the recipient the right to stagnate. Medicine must be a continuing program of education for its members who are doctors in fact as well as name. If many of them do not consider the sacrifice too great to give up one or more years of practice for additional hospital or postgraduate training to improve their professional stature, is it not reasonable to expect osteopaths to do as much if they desire professional equality?

CHARLES J. COLLINS, M.D. ORLANDO

Physical Examination for Driver Education Program in the Public Schools

The problem of accidents is one of our number one health problems. It is the leading cause of death in the preschool and school age group. It is responsible for 31.2 per cent of all deaths in the age group one to four years, 48.3 per cent of all deaths ages five to nine years, 49.3 per cent ages 10 to 14 years, and 52.6 per cent ages 15 to 19 years.

Many factors enter into the high death rate due to accidents. Much energy and effort are being made to lower the morbidity and mortality rates. Motor vehicle accidents take their toll. One of the ways of lowering this rate is by teaching better driving of motor vehicles. The State Department of Education is responsible for the Driver Education Program which became effective July 1, 1963. All students taking this course will be required to have a physical examination prior to registration for the course in the public schools.

Each member of the Florida Medical Association will receive along with BRIEFS a copy of the physical examination form to be used for the examination and instructions for its use. Each high school student who expects to take the Driver Education course next fall will be given a blank physical examination form by the school and advised to go to his physician during the summer months and have the examination made. Physicians may obtain blanks for this purpose from the county health unit. It might be well for each physician to have a supply of these forms readily available in his office.

One of the many problems in our school health program is the lack of satisfactory arrangements in many counties whereby the children in the public schools can secure regular physical examinations. It is possible with the Driver Education Program for almost all physicians of the state to have a part in this program by making the examinations for their patients. From this examination and the follow-up of the physical defects found, it should mean better health for our young people and an experience for the pupils which will lead them to consider their own health more

seriously. It will also help to lower our motor vehicle accident rate by keeping the physically unfit from driving a car along our public roads.

The examination record MCH 304-B is prepared with code numbers so that data can later be assembled on IBM cards. This provision will make it possible to obtain information on the health of the school child on a school county, state or sampling basis.

Each physician is urged to complete the physical examination record as carefully as possible. It is believed that this is a step forward in working with the public schools of the state to promote better health for our school children.

WILSON T. SOWDER, M.D. JACKSONVILLE



1963 Annual Meeting

OPPOSITE PAGE: 1. Dr. Robert E. Zellner of Orlando, President of the Florida Medical Association, addresses the House of Delegates. 2. The Hon. Roman L. Hruska, United States Senator (R-Nebraska) delivers an address as the guest of Dr. Zellner. 3. Dr. Warren W. Quillian of Coral Gables is escorted to the platform by Dr. Walter C. Jones of Miami for ceremonies which installed Dr. Quillian as the Eighty-Third President of the Association. 4. The officers of the Association assemble following their election. They are (from left) Dr. H. Phillip Hampton of Tampa, Vice President; Dr. Floyd K. Hurt of Jacksonville, Secretary-Treasurer; Dr. Zellner, who became the Immediate Past President; Dr. Quillian, President; Dr. Samuel M. Day of Jacksonville, President-Elect, and Dr. Eugene G. Peek Jr. of Ocala, Speaker of the House. 5. Dr. Day accepts the office of President-Elect after having served for 12 years as Secretary-Treasurer. 6. Dr. Peek welcomes the Hon. Mallory Horne, Speaker of the House of Representatives, State of Florida. Dr. Edward R. Annis of Miami, President-Elect of the American Medical Association, presented Mr. Horne to the House of Delegates. 7. Mrs. Edward W. Ludwig of Jacksonville, President of the Woman's Auxiliary to the Florida Medical Association (left), and Mrs. Abbott Y. Wilcox Jr. of St. Petersburg, President-Elect (right), introduce Mrs. C. Rodney Stoltz of Watertown, S. Dak., guest of Mrs. Ludwig. 8. Dr. Jere W. Annis of Lakeland receives the A. H. Robins Company Award from Dr. Zellner "For Outstanding Community Service by a Physician.



Clinical



Florida Orthopedic Society Meeting

The Florida Orthopedic Society held its fall meeting on October 20-21, 1962, in Boca Raton. Moderator William F. Enneking, M.D., of Gainesville introduced the guest speaker, Floyd E. Bliven Jr., M.D., from the Medical College of Georgia, Augusta, who gave a presentation on "Performance and Disability Evaluation." He stressed the evaluation of physical capacity, motivation, intelligence, activities of daily living, work and recreation, as well as the patient's reserve capacity.

Moderator Wallace E. Miller, M.D., of Miami in the afternoon session introduced James L. West Jr., M.D., and George R. Rieth Jr., M.D., of St. Petersburg, whose presentation was "L'Episcopo

Emory Postgraduate Seminar !N

Gynecology and Obstetrics offered by

The Department of Gynecology

Obstetrics Emory University School of Medicine

OCTOBER 17, 18, 19, 1963

Faculty:

Denis Cavanagh, M.D. University of Miami School of Medicine

Robert Noyes, M.D. Vanderbilt University School of Medicine

and

Members of the Faculty of Emory University School of Medicine 69 Butler Street, S.E. Atlanta 3, Georgia

Reconstruction for Erb's Palsy." The authors presented three cases and discussed the pathology of obstetrical paralysis amenable to the L'Episcopo type of transplant. The three patients were aged seven and eight.

Richard M. Fry, M.D., of Gainesville presented a paper on "Tumors of the Hand," describing a series of 337 cases of hand tumors drawn from a large Hand Clinic during the years 1959 and 1960. Of these tumors, 190 were ganglia.

Hugh B. Haston Jr., M.D., of Jacksonville presented a paper discussing "Marfan's Disease" and stressed the sudden demise due to cardiovascular accident occurring frequently in patients with this disease.

Richard A. Worsham, M.D., of Jacksonville introduced Robert P. Keiser, M.D., of Coral Gables, who discussed "Transplantation of the Anterior Tibial into the Os Calcis for Restoration of Paralytic Calcaneus." The records of 17 patients with pes calcaneus were reviewed; 10 were treated by anterior tibial tendon transplant alone, four by anterior tibial plus peroneus longus transfer, and three by combination of fusion plus multiple transfers.

Robert C. Field, M.D., of Orlando presented a paper on "Elective Surgery in Hemophilia." He presented three cases of hemophilia with acquired equinus deformity, which appears to be the result of single severe or repeated smaller hemorrhage in the gastrocnemius group of muscles. The preoperative and postoperative management for Achilles tenotomy, posterior capsulotomy of the ankle and lengthening of the posterior tendons was discussed, specifically as regards the use of human fibrinogen rich in antihemophilic globulin to control hemorrhage in patients with this disease.

Augusto Sarmiento, M.D., of Miami presented a preliminary report of 33 cases of "Bone and Joint Infections," treated by debridement and primary closure, using isolated extremity perfusion of antibiotics, combined with total excision of the infected area, whether it be bone or synovial

Dr. Bliven's presentation of "Tuberculosis of Bone" concluded the program. Dr. Bliven discussed pathogenesis and treatment and made special comment on his experience with the atypical type III Battey strain.

> JAMES F. RICHARDS JR., M.D. ORLANDO



BULK IS BASIC

METAMUCIL® IS BASIC...

(brand of psyllium hydrophilic mucilloid)

Metamucil corrects constipation in pregnant patients without disturbing either the rhythmic or digestive functions of the gastrointestinal tract.

By adding a soft, hydrophilic, easily-compressed bulk to the diet, Metamucil augments and reinforces the natural bulk stimulus to intestinal peristalsis and the defecation reflex. This purely local action softens hard fecal masses, increases muscle tone and helps reestablish the normal rhythm of elimination.

Since its action is not systemic and not

habit forming, Metamucil may be safely administered throughout pregnancy.

Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid.

Metamucil is available as Metamucil powder in 4-,8- and 16-ounce containers and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

G. D. SEARLE & CO., Chicago 80, Illinois Research in the Service of Medicine

J. Florida M.A./July, 1963

A COMPLETE BUSINESS SERVICE

lanagemen

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Avenue, N. E. St. Petersburg, Florida Phone 862-6903



314B John Ringling Blvd Sarasota, Florida Phone 388-1604

> Box 514 Miami 62, Florida Phone 945-4055

Affiliates of Black & Skaggs Associates Battle Creek, Michigan

HCV CREME

3% Iodochlorhydroxyquin 1% Hydrocortisone

Provides ANTIFUNGAL, ANTIBACTE-RIAL, ANTI-INFLAMMATORY AND AN-TIPRURITIC action in dermatitis.

GEVIZOL

Each 5 cc. tspfl or tablet provides 100 mg. Pentylenetetrazol, 50 mg. Nicotinic acid.
GEVIZOL is indicated in the treatment of the mentally confused, emotionally unstable, apathetic aged and aging patient. For the patient complaining of dizziness or fogginess. Reactivates the inactivated.

PHARMACAL
CORPORATION

St. Petersburg

Florida

FIRST EXPLOSION-PROOF

Surgical Headlight

The only headlight approved by Underwriters' Laboratories for use with explosive gases. Completely self-contained—no trailing cords. Rechargeable batteries worn by surgeon on belt. Sterilizable. Brilliant, co'or-corrected, focusing light. Separate recharger unit.

WELCH ALLYN (R)







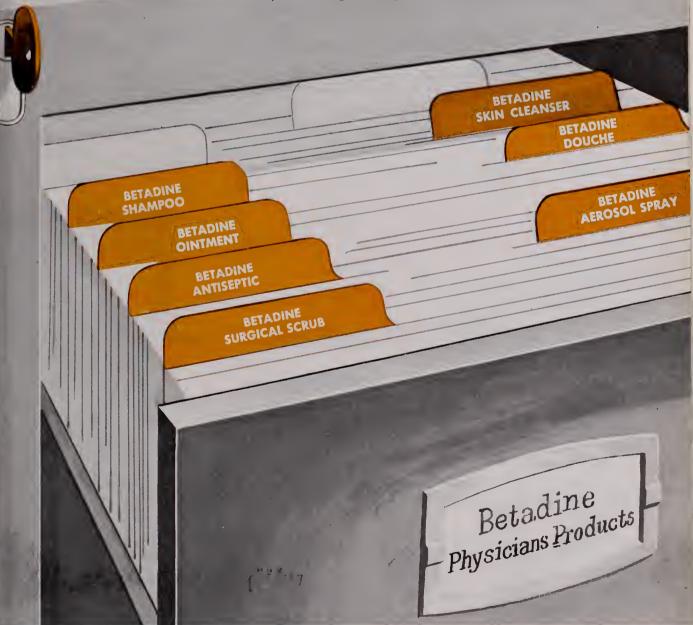


etadine vidone-lodine roducts lock a wide nge of usefulness

Betadine Products, in all seven dosage form contain povidone-iodine, a complex of polyving pyrrolidone and iodine, providing all the germ cidal properties of elemental iodine . . . yet Bet dine (povidone-iodine) is nonirritating, nonsens tizing, and nontoxic to skin or mucosa.

Betadine Products are effective in preventing an treating a variety of infections frequently elecountered in the practice of otolaryngology, orthogodics and orthopedic surgery, obstetrics an gynecology, oral surgery, pediatrics, surgery and dermatology.

The clinical results reported under various corditions of use make Betadine (povidone-iodine preparations valuable adjuncts both in the hopital and in private practice. Literature available upon request.





PRODUCTS CO., INC.
PETERSBURG, VIRGINIA

News

The scientific exhibit, "Glaucoma Screening," presented at the 89th Annual Meeting of the Florida Medical Association in Hollywood by the Florida Society of Ophthalmology and Otolaryngology and the Florida State Board of Health, won the First Place Award. Second Place Award went to the exhibit entitled "Arthrography of the Knee in Office Practice" presented by Drs. Thomas W. Dorr, Ralph C. Aye and Garth R. Drewry of Tampa. Honorable Mention Awards were presented to the exhibits entitled "Florida-Territory to Statehood," Committee on Archives, Florida Medical Association, Dr. Clifford C. Snyder, Coral Gables, Chairman: "The Spastic Child: Modern Treatment," Dr. Charles M. Carter, Orlando, and "Florida's Summer Camp for Diabetic Children," Dr. Joseph C. Shipp, Gainesville.

Dr. Truxton L. Jackson of Miami with the first low net won the Duval County Medical Society trophy at the annual Florida Medical Association Golf Tournament held at the New Presidential Country Club at Hollywood during the Annual Meeting of the Association. Dr. Julian A. Rickles of Miami was presented the Orlando Loving Cup as the sixth low net winner. Other low net winners were Dr. Philip J. Chastain of Coral Gables, second; Dr. Harry M. Permesly of Hollywood, third; Dr. William M. C. Wilhoit of Pensacola, fourth, Dr. William P. Smith of Coral Gables, fifth; Dr. Rickles, sixth; Dr. Curtis D. Benton Jr. of Fort Lauderdale, seventh; Dr. Paul J. McCloskey of Tampa, eighth, and Dr. James S. Bates Jr. of Hollywood, ninth.

Dr. Louis J. Polskin of Lakeland won the first award for attendance at the Technical Exhibits of the 89th Annual Meeting of the Florida Medical Association held in Hollywood. Dr. Bernard J. McCloskey of Jacksonville won the second award and Dr. Robert L. Levine of Hialeah third award. Dr. Polskin's award was one day's interest at 11 per cent on a million dollars; Dr. McCloskey's one day's interest at 5.5 per cent on a million dollars, and Dr. Levine's one day's interest on the same amount at 2.75 per cent.

increases
blood flow
to the brain
in the
"senility syndrome"
associated
with
cerebrovascular
insufficiency



Dr. Herbert E. Kaufman of Gainesville, Chief of Ophthalmology at the University of Florida College of Medicine, has been presented the Albion O. Bernstein, M.D., Annual Award of the Medical Society of the State of New York for his research work with a new antimetabolic drug in the treatment of herpetic keratitis, herpes simplex of the cornea and in dendritic keratitis.

Dr. W. Dean Steward of Orlando has been elected president of Blue Shield of Florida. Chosen with Dr. Steward at the annual meeting in Hollywood on May 16 were Dr. John S. Stewart of Fort Myers as vice president, Judge Ben C. Willis of Tallahassee, re-elected vice president; Dr. John T. Stage of Jacksonville, re-elected secretary, and Dr. Leo M. Wachtel of Jacksonville, as treasurer.

Dr. Edward R. Annis of Maimi has been named president-elect of the World Medical Association. He will serve in this capacity until October at which time he will be installed as president during ceremonies at the 17th World Medical Assembly in New York. Dr. Annis, who became

the 117th president of the American Medical Association on June 18, is the second American to be so honored by the World Medical Association.

Edward Joseph Duffy, a student at Stranahan Senior High School in Fort Lauderdale, was one of the two winners of the American Medical Association's awards at the 14th National Science Fair held early in May at Albuquerque, N. Mex.

Dr. Alfons R. Bacon of Sarasota has been appointed Clinical Assistant Professor Emeritus in the Department of Obstetrics and Gynecology at the University of Illinois College of Medicine.

The Third Annual Dixie Postgraduates Assembly has been scheduled for July 17-19 at the Tutwiler Hotel in Birmingham. The meeting has been accepted for 14 hours Category I credit by the American Academy of General Practice.

Drs. Raymond J. Fitzpatrick of Gainesville, Harold O. Hallstrand of Miami and Carl S. Mc-Lemore of Orlando have completed a 31 day tour of Central and South America sponsored by the Foreign Service of the United States of America through the International College of Surgeons.



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems. 1-3

43% increase in cerebral blood flow

In patients with cerebrovascular insufficiency, Eisenberg⁴ measured a 43 percent increase in blood flow in the brain following administration of Arlidin (nylidrin HCl) orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

Winsor and associates³ found Arlidin (nylidrin HCI) "of particular value clinically in relieving some of the symptoms of cerebral vascular insufficiency (vertigo, lightheadedness, mental confusion, diplopia)."

arlidin[®] BRAND OF NYLIDGE HCI

SUMMARY: Indicated whenever an increase in blood supply is desirable in circulatory insufficiencies of the extremities, brain, eye and ear. Use with caution in the presence of a recent myocardial lesion, severe angina pectoris and thyrotoxicosis. Contraindicated in acute myocardial infarction.

REFERENCES: 1. Madow, L.: Penn. M. J. 62-861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Labs., division • 800 Second Avenue, New York 17, N. Y.

CLASSIFIED

FOR RENT: Complete office. Ready to move into in the Doctors Building. \$110. per month including air-conditioning, heat, hot water and janitor service. Downtown location, abundance of free parking for patients. Contact S. J. Wilson, M.D., 309 N. E. River Drive, Fort Lauderdale, Fla.

WANTED: General Practitioner, Internist, Pediatrician, to join surgeon in new clinic. Exciting growth enterprise in finest Cape Canaveral location. Arrangements open. Write 69-484, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Excellent general practice and equipment, Miami Beach area, established 30 years same location. Contact: Medical Business Consultants, 1101 N.E. 79th Street, Miami, PL 9-0230.

PEDIATRICIAN WANTED: For association in Hollywood, Fla. Must be Board qualified or certified. For information contact Medical Business Consultants, 1101 N.E. 79th St., Suite 205, Miami, Fla. Telephone PL 9-0230.

WANTED: Pediatrician, ENT, Internist and Dermatologist for new medical building ready Feb. 15. Adjacent to hospital in beautiful location on Gulf of Mexico. Fine practice opportunity. Write 69-510, P.O. Box 2411, Jacksonville, Fla.

MEDICAL OFFICE AVAILABLE: Unusual opportunity for GP or specialist in Miami Beach. Call Jefferson 1-1246 or contact: Dr. Leonard Sakrais, 1500 Bay Rd., Miami Beach, Florida.

OFFICE FOR RENT: Share waiting and reception area with dentist in an office in a professional building. Parking. Three 10 by 10 rooms plus bathroom. Rent \$160. Share utilities. Write Dr. Steven H. Rose, 1119 South Flagler Dr., West Palm Beach, Fla

INTERNIST WANTED: To occupy adjoining office and work in cooperation with established internist. Good residential area on East coast. Write 69-536, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER OR EAR-NOSE-THROAT: Available about Sept. 1, 1963. The choicest of location for a GP or ear-nose and throat specialist. A five room suite of offices with separate waiting room. Modern with plenty of off-street private parking. The very best hospital facilities only one block away. Lots of referrals. Located in the medical center of the south. Lakeland, Florida. Rent \$200 month. Call MU 81294 collect.

OPHTHALMOLOGIST WANTED: For unopposed excellent location East coast. Good cooperation from other physicians. Rent concession until established. Write 69-537, P.O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN WANTED: To work in cooperation with obstetrician in unopposed high grade residential area. Flexible rent arrangement. Write 69-538, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Solidly established Miami Beach general medical practice and equipment. Will introduce and cooperate fully. Leaving practice for psychiatry residency in this area. Write or phone Dr. Greenberg, 350 Washington Ave., Miami Beach. JE 1-7057.

PEDIATRICIAN WANTED: Board eligible, Florida licensed, with view of complete transfer of practice in near future. On West coast in middle-class community near good hospitals and universities. Write 69-528, P.O. Box 2411, Jacksonville, Fla.

AVAILABLE LATE 1963: Experienced general surgeon, 38, family, military obligation completed. Certified American Board of Surgery; F.A.C.S.; 7 years practice general and vascular surgery, last 3 geographic full-time including surgery, laboratory and clinical investigation, resident teaching and administrative experience; author scientific publications and exhibit; Florida license; policy change requires relocation; desires institutional, group or partnership practice. Travel for interview. Reply to 69-525, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER: I will sublet my office in West Palm Beach to a qualified physician, Rent. including use of my equipment, \$175. per month. Write 69-530, P.O. Box 2411, Jacksonville, Fla.

TWO SUITES AVAILABLE: New modern Medical-Dental building, air-conditioned, plumbing-partitioning-parking. Three dentists occupy two suites. Ideal location Fort Lauderdale for General Practitioner and for specialists. Write 69-533, P.O. Box 2411, Jacksonville, Fla.

WANTED: To share with General Practitioner; medical building space available for two physicians. Winter Park area, convenient to hospital, attractive surroundings. For additional information write: Richard R. Hayes, M.D., 185 N. Lakemont, Winter Park, Fla.

OFFICE SPACE FOR RENT: Medical suite, approximately 600 sq. ft. in separate consultation, two treatment and laboratory rooms. Share secretary and reception room. New professional building, excellent furnishings. Suitable for specialty or general practice. Clarence H. Schilt, M.D., 2161 McGregor Bldg., Ft. Myers, Fla.

BRAWNER HOSPITAL. INC.

(Established 1910)

2932 South Atlanta Road, Smyrna, Georgia

FOR THE TREATMENT OF PSYCHIATRIC ILLNESSES
AND PROBLEMS OF ADDICTION
MODERN FACILITIES

JAS. N. BRAWNER, JR., M.D. Medical Director

ALOYSIUS I. MILLER, M.D. MARK A. GOULD, M.D.

Phone HEmlock 5-4486

WANTED: General Practitioner for Clinic-Hospital. Salary open—plus bonus. Write 69-535, P.O. Box 2411, Jacksonville, Fla.

ADMINISTRATIVE MEDICINE: U.S. Vocational Rehabilitation Administration, Medical Consultant for region comprising Alabama, Florida, Georgia, Mississippi, South Carolina and Tennessee with head-quarters in Atlanta, Georgia. Salary comparable with Medical Director, Public Health Service, or Civil Service Grade 15 (begins \$14,565). For further information contact Mr. Louis R. Schubert, Regional Representative, Vocational Rehabilitation Administration, Room 404, 50 Seventh St., Atlanta 23, Ga.

PHYSICIAN WANTED: For full time position in occupational medicine for large Industrial Plant located in Central Florida. This is an interesting and challenging job. Experience in industrial medicine desirable but not mandatory. Florida license required. Applicants should send a resume of their qualifications to: Industrial Relations Department, American Cyanamid Company, Brewster Plant, Bradley, Florida.

AVAILABLE: For \$90 enjoy professional suite of 4 rooms air-conditioned in Medical Arts Building, 503 W. Platt, Tampa. Phone 251-1600.

FOR SALE OR RENT: Well equipped GP office of Arthur T. Rask, M.D. for price of equipment and a small amount for records and good will. Reasonable office rent. Located in center of Lake Worth, Florida. Established 10 years. Good hospitals. For information contact Calder Properties, Inc., 907 Lake Avenue, Lake Worth, Fla.

PROFESSIONAL SUITE: Reception room with nurse's station. Five consulting and examining rooms. Built to a doctor's specifications. Ample space to serve two doctors. Street level. Centrally heated and air-conditioned. Five minutes from Bethesda Memorial Hospital. Ample parking. Immediate occupancy. VERY reasonable rent. 275 N.E. 2nd Ave., Delray Beach. Call Owners or your broker. CR 6-7092 or CR 6-7634. Booth Westerman, Inc., P.O. Box 2013, Delray Beach, Fla.

PRACTICE FOR SALE: Ideal for two well suited E.E.N.T. specialists in thriving community where you are needed. Congenial colleagues will support you. 2,600 sq. ft. of air-conditioned space. Off street parking. Modern equipment and complete instruments for examinations of Ophthalmology and Otolaryngology. Deceased was diplomate of O.L.A.R. and member F.A.C.S. Office established over 30 years. For details write Mrs. J. N. McLane, 1212 N. Palafox St., Pensacola, Fla.

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets before meals and at bedtime. Individualization required.

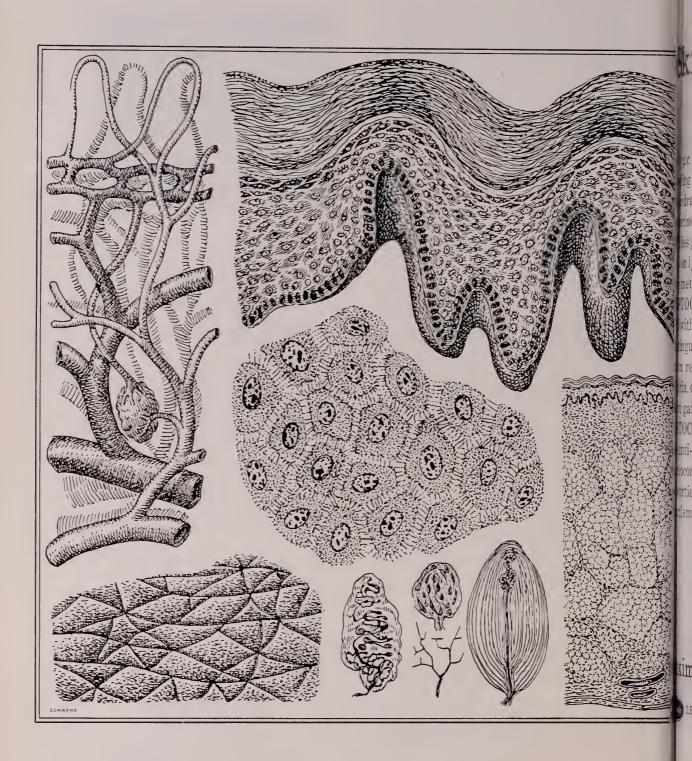
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

Wallace Laboratories / Cranbury, N. J.



kin Deep

ing psoriasis, have in many patients dramatic response to ARISTOCORT cinolone systemic therapy. But it also des gratifying symptomatic control only minimal interference with metabolic functions. In this respect, TOCORT Triamcinolone, when comwith other corticosteroids, old and new, inguished. Typical steroid problems of m retention and edema, undesirable ria, or voracious appetite and excessive t gain rarely occur.

TOCORT Triamcinolone is indicated anti-inflammatory, anti-allergic action cocorticoids is desired. SIDE EFFECTS of orticoids generally: Cushingoid effects, tism, leucopenia, purpura, vertigo,

fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

PRECAUTIONS: ARISTOCORT Triamcinolone should be used with extreme caution in viral infection, particularly herpes simplex and chicken pox, in tubercular or fungal infection, in active peptic ulcer, acute glomerular nephritis or myasthenia gravis. FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup—2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

Aristocort Triamcinolone

ximum steroid benefits with minimum steroid penalty

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

For the Patient Over 50 with Digestive Distress

KANUMODIC

Each tablet contains methscopolamine nitrate, 2 mg.; and pentobarbital (Warning: May be habit-forming), 8 mg.; plus KANULASE® (cellulase standardized to 9 mg.; combined with pepsin, N.F., 150 mg.; glutamic acid hydrochloride, 200 mg.; pancreatin, N.F., 500 mg.; ox bile extract, 100 mg.).

TE	ES	TE	D.	-P	R	O	V	EI	D
----	----	----	----	----	---	---	---	----	---

25 Patients	1
Table I—Symptomatic Relief in 25 Patients (totalling 100 symptoms) TOTAL SYMPTOMS	F
Table I—Symptomatic Relief NO SYMPTOMS SYMPTOMS	1
Table I—Symptoms 100. Symptoms NO SYMPTOMS	1
	1
T COMPLETE BELIEF 1 100	
RELIEF 24	1
50 17 95	
59 61	7"
KANUMODIC 1 33 61	
NA.	N
PLACEBO	
PLA	-4
symptoms. A follow up study of 60 addi	

In a second study, Kanumodic produced "highly gratifying symptomatic relief" in 46 of the 60 patients participating.

Tested in patients over 50*... The effectiveness of Kanumodic was matched against placebo response in a study involving twenty-five "over 50 patients" suffering from functional bowel distress. All patients complained of one or more

symptoms. A follow-up study of 60 additional cases (average age, 55.3 years) was also conducted.

Proved in patients over 50*... The response noted in the pilot study is charted above.

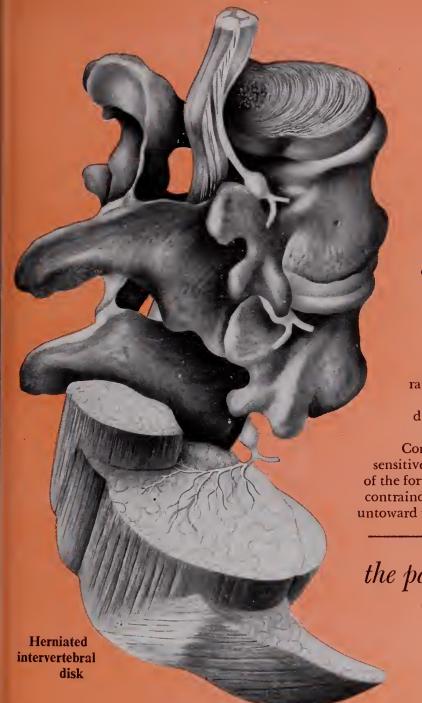
*McHardy, G., and Balart, L.: Curr. Ther. Res. 4:153, 1962.

Dosage: 1 or 2 tablets, swallowed whole with each meal.

Cautions: Federal law prohibits dispensing without prescription. Side effects such as dryness of mouth, blurring of vision, and urinary retention may occur occasionally with large doses. This product is contraindicated in the presence of glaucoma or prostatic hypertrophy. Glutamic acid hydrochloride is usually not given to patients with peptic ulcer.

DORSEY LABORATORIES

Lincoln, Nebraska



When pain is prominently associated with skeletal muscle spasm, Robaxisal effectively combats both pain and spasm. If sedation is also indicated, prescribe Robaxisal-PH.

Side effects, such as lightheadedness, slight drowsiness, dizziness, and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

Contraindicated for patients hypersensitive to aspirin or other components of the formulations. There are no specific contraindications to methocarbamol, and untoward reactions are not to be expected.

the patient had

pain S

spasm'*



*Skeletal muscle spasm is a two-headed dragon of 'PAIN & SPASM'

ROBAXISAL®

Minmuth

A T® TOT

ROBAXISAL-PH

Each green-and-white laminated ROBAXISAL-PH tablet contains: ROBAXIN 400 mg. Phenacetin (1½ gr.) 97 mg. (methocarbamol, Robins) Aspirin (1½ gr.) 81 mg.

Hyoscyamine sulfate 0.016 mg. Phenobarbital (1/8 gr.) 8.1 mg. (Warning: May be habit-forming)

A. H. ROBINS CO., INC., Richmond 20, Virginia





wPATHILON ``SEQUELS'' with Phenobarbital

TRIDIHEXETHYL CHLORIDE Sustained Release Capsules Each capsule contains: Tridihexethyl chloride...75 mg.; Phenobarbital...45 mg.

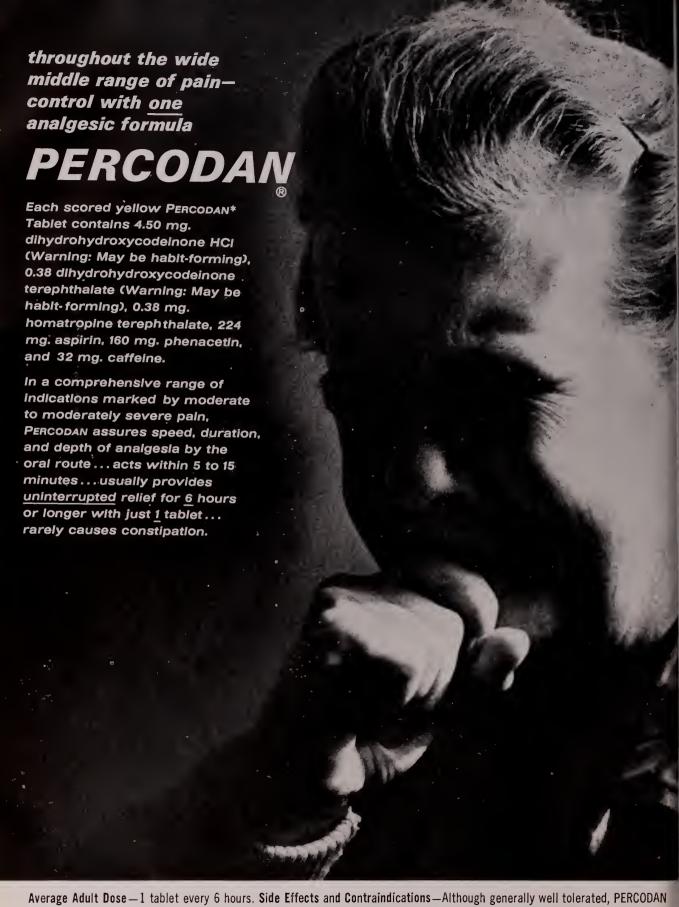
mulated for controlled release of the active edients, for sustained anticholinergic proion against spasm and pain in the G.I. tract, vell as sustained phenobarbital action.

ninates the necessity for numerous doses; ens out "peaks and valleys" in drug blood Is that can minimize effectiveness; and rees protective medication through the night. Ective in organic and functional disorders he gastrointestinal tract (duodenal ulcer, estinal colic, ileitis, esophageal spasm, stinal spastic colon, alcohol-induced G.I. ets, gastric hypermotility) and anxiety

neurosis with G.I. symptoms. Should be used as an adjunct to other measures. Side Effects due to tridihexethyl chloride: dry mouth, blurring of vision, constipation. Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention. Supply: Bottles of 30 and 500.

Also available: PATHILON SEQUELS (without phenobarbital) Tridihexethyl chloride, 75 mg. Bottles of 30 and 500.





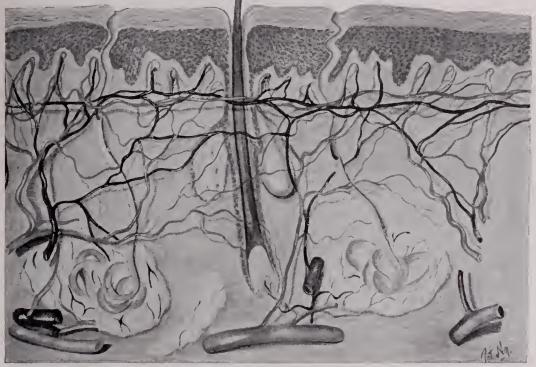
Average Adult Dose—1 tablet every 6 hours. Side Effects and Contraindications—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. Also available: PERCODAN®-DEMI.

containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxy-codeinone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. Literature on request.

ENDO LABORATORIES Richmond Hill 18, New York

Endo

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B —bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of non-susceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Supplied: Tubes of 1 oz., $\frac{1}{2}$ oz. with applicator tip, and $\frac{1}{8}$ oz. with ophthalmic tip. Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'

POLYMYXIN B-BACITRACIN-NEOMYCIN ANTIBIOTIC OINTMENT



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders and Invalids Alcoholics Treated



5226 Nichol St. Telephone 61-4191

DON SAVAGE Owner and Manager

Aged adjudged cases will be accepted on either permanent or temporary basis.

Safety against fire — by Automatic Fire Sprinkling System.

Cyclone fence enclosure for recreation facilities, seventy-five by eighty-five feet.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by American Medical Assn. American Hospital Assn. Florida Hospital Assn.

> P. O. Box 10368 Tampa 9, Florida

HIGHLAND HOSPITAL, INC. FOUNDED IN 1904 ASHEVILLE, NORTH CAROLINA

Affiliated with Duke University





A non-profit psychiatric institution, offering modern diagnostic and treatment procedures-insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders.

The Hospital is located in a 75-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D. Medical Director

ROBERT L. CRAIG, M.D. Associate Medical Director JOHN D. PATTON, M.D. Clinical Director



NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

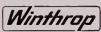
NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

NTZ® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains Neo-Synephrine® HCI 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; Thenfadil® HCI 0.1% for topical antiallergic action; and Zephiran® CI 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U. S. Pat. Off.



Winthrop Laboratories New York 18, N.Y.



FROM START TO FINISH

You can be assured that your GUILD OPTICIAN uses only
the finest materials to compliment precision workmanship.

For the GUILD OPTICIAN knows that skilled
craftsmanship must be combined with superior
materials. The result is the ultimate in precision eye wear.



SOCLOR TIMESULE

OR TIMESULE CONTAINS:

ramine maleate 10 mg. rine HCL 65 mg. Il form providing prolonged effect.



A NEW COMPREHENSIVE RELIEF

- Relief usually starts in minutes—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
- Relief usually lasts up to 12 hours with a single oral dose
- Gives both upper respiratory decongestion and bronchodilatation to relieve chest discomfort
- With minimal drowsiness, CNS or pressor stimulation

MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

DOSE: Adults: One Timesule every 12 hours, or as directed.

warning: Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

Send for Samples and Literature





YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office
JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO

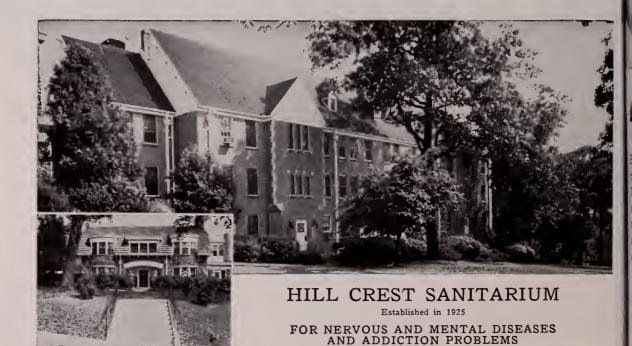
1511 Sligh Blvd. Telephone GA 5-3537

Convention Press

218 W. CHURCH ST. JACKSONVILLE, FLORIDA

QUALITY
BOOK PRINTING
PUBLICATIONS
BROCHURES

W HATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine quality work—and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.



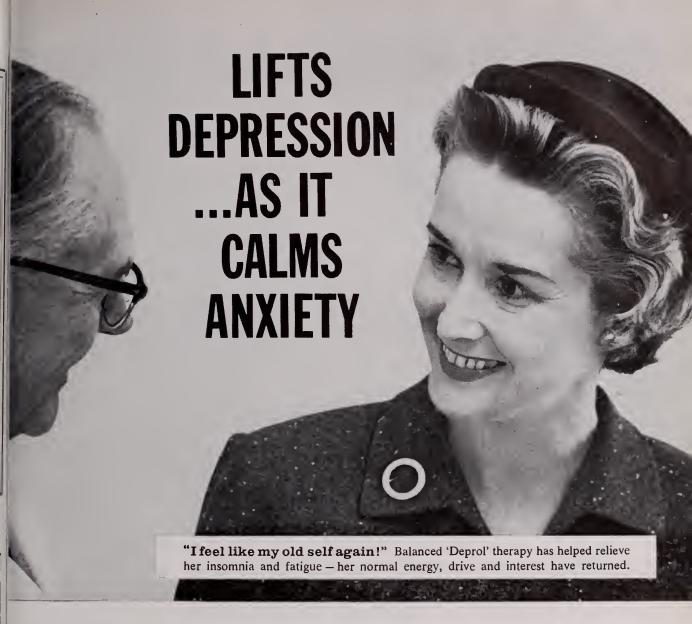
Out-Patient Clinic and Offices

James A. Becton, M.D.

P. O. Box 2896, Woodlawn Station, Birmingham 6, Ala.

James Keen Ward, M.D.

Phone WO 1-1151 and WO 1-1152



Brightens mood ... relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

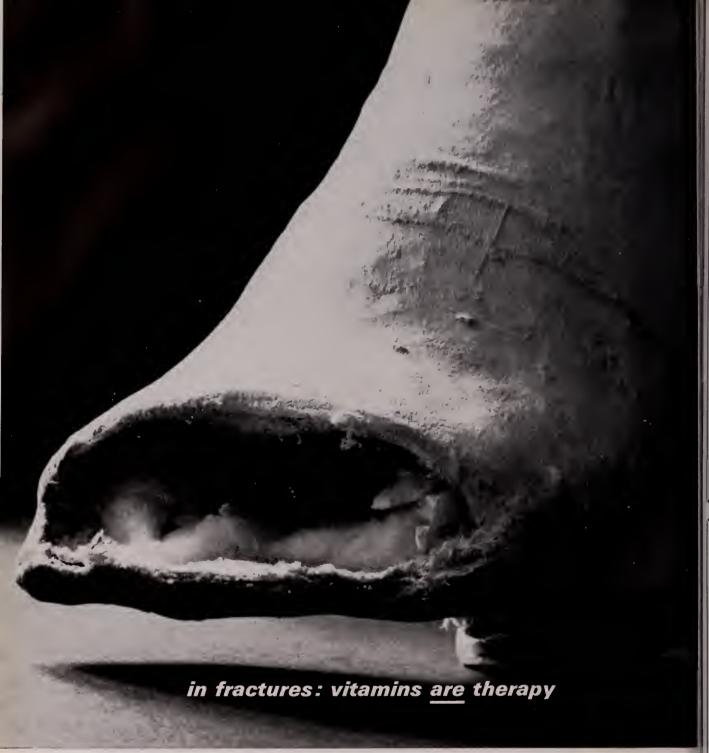
Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

Deprol meprobamate 400 mg.

+ benactyzine 1 mg.

WALLACE LABORATORIES / Cranbury, N.J.





Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery.

Each capsule contains: Vitamin B₁ (Thiamine Mononitrate)...10 mg. / Vitamin B₂ (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B₆ (Pyridoxine HCl)...2 mg. / Vitamin B₁₂ Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.





Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y

Stress Formula Vitamins Lederle

TUCKER HOSPITAL, INC.

212 West Franklin Street RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological patients. Hospital and out-patient services.

(Organic diseases of the nervous system, psychoneuroses, psychosomatic disorders, mood disturbances, social adjustment problems, involutional reactions and selective psychotic and alcoholic problems.)

Dr. James Asa Shield Dr. George S. Fultz, Jr. DR. WEIR M. TUCKER DR. W. FREDERICK YOUNG

APPALACHIAN HALL

ASHEVILLE

Established 1916

NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin Jr., M.D. Robert A. Griffin, M.D.

Mark A. Griffin Sr., M.D. Mark A. Griffin Jr., M.D.

For rates and further information write Appalachian Hall, Asheville, N. C.

Specialized Service

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

कि:03

MENDICAL PROPERTY CONDUCTOR

PORT WATER TODIANA

Professional Protection Exclusively since 1899

MIAMI OFFICE: H. Maurice McHenry, Rep. 149 Northwest 106th Street, Miami Shares Tel. Plaza 4-2703

The distinctive PREMIERE suite

By Hamilton

Smartly styled and finished entirely in lifetime materials. Wood-grained Formica in gray or cream, satin-finish stainless steel and bright chrome create a contemporary, fully Professional atmosphere — and the Premiere will keep its dignified look for a lifetime. Five essential pieces in the suite; table, instrument cabinet, treatment cabinet, waste receptacle and stool. The table is extra large and has a new contour upholstered top to give patients more comfort and security. Other innovations on the table include adjustable chrome legs for leveling or raising the table. The usual features of Hide-A-Roll, treatment basin and pull-out step are included.

Versatility is the keynote of the Premiere suite. The upper section of the instrument cabinet can be used separately as a wall cabinet and the lower section as a treatment stand. This option allows a greater variety of room arrangement according to personal preference and requirements.

See the new Premiere and other Hamilton suites in wood and steel now.

Anderson Surgical Supply Co.

ESTABLISHED 1916

Phone CHerry 1-9589 1616 N. Orange Ave. Orlando Phone 896-3107 556 9th St. S. St. Petersburg Phone 229-8504 Morgan at Platt Tampa

Phone 376-8253 729 S.W. 4th Ave. Gainesville

A special margarine for the atherosclerosis diet

The latest report* in the JAMA on atherosclerosis diets states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

Since this report recognizes table spreads as an important source of dietary fat, we believe that it is in your professional interest to know about the fatty-acid composition of Mrs. Filbert's Corn Oil Margarine.

Mrs. Filbert's Corn Oil Margarine is a special margarine** made from 100% corn oil, over 50% of which retains its liquid characteristics.

Because of its high linoleic content, its ratio of polyunsaturates to saturates is about 1.7 to 1... and equals the highest level available today in *any* corn oil margarine.

Of the total fatty acid content, 28% is cis-cis linoleic acid.

Moreover, when you recommend Mrs. Filbert's Corn Oil Margarine, your patient is assured of receiving unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).

**AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



Made from 100% corn oil with liquid corn oil as its major ingredient

For additional information—including detailed listings of component characteristics—please write to us.

J. H. FILBERT, Inc.

BALTIMORE 29, MARYLAND

J. Florido M.A./July, 1963 97

A Hospital Using
the Modern Concepts of
Intensive Psychiatric
Treatment
Owned and Operated
by the
Anclote Manor Foundation
A Non-Profit Organization

ANCLOTE MANOR

MEDICAL DIRECTOR Loront Forizs, M.D.

CLINICAL DIRECTOR Wolter H. Wellborn, Jr., M.D.

DIRECTOR OF TRAINING Theodore H. Gogliono, M.D.

STAFF PSYCHIATRISTS Robert G. Zeitler, M.D. Richard L. Meadows, M.D. Chos. J. Soporito, M.D.

ADMINISTRATOR Fred P. Ryder, M.H.A.



The hospitol is oriented for Individuol Psychotherapy, Group Psychotheropy, Theropeutic Community, oll Somatic Theropies, The lorge stoff is troined for Teom Approach. Recreation by prescription.

SAMUEL G. HIBBS, M.D., F.A.P.A.

President of the Board

Chief Consultant in Psychiatry

Consultants in Psychiatry
Walter H. Bailey, M.D., F.A.P.A.
Arturo Gonzalez, M.D.
Saul C. Holtzman, M.D.
Alfred D. Koenig, M.D.
Martha W. MacDonald, M.D.
Roger E. Phillips, M.D.
Zack Russ, Jr., M.D., F.A.P.A.
Peter J. Spoto, M.D.
Robert G. Steele, M.D.
Samuel G. Warson, M.D., F.A.P.A.

Member Notionol Associotion of Privote Psychiotric Hospitols, American Hospitol Associotion, Florido Hospital Associotion. Approved by American Psychiatric Association, Accredited by Joint Commission on Accreditation of Hospitols.

Located at TARPON SPRINGS, Florida — Phone: 937-4211

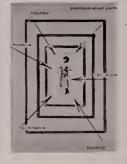
2 Years-No Treatment

THEY DO NOT RECOVER— SPONTANEOUSLY

They need combination treatment; multiple clinical evaluations are proving this.

Add to your routine medical or surgical management ONE OF THE PHYSICAL AGENTS especially designed for your office or home use. For pain, edema and as a decongestant, FORTIFY muscular relaxants with ultrasonic energy.

For facial and small muscular rehabilitation, add the specially designed Zeigler Model Y-4.



Madel Y-4
Far Office or Home Use





U. S. Model 108

ZEIGLER OF FLORIDA, INC.

495 Biltmore Way, Coral Gables 34, Fla., Phone 444-5283

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
ola Medical Association Frida Specialty Societies a my of General Practice ley Society chesiologists, Soc. of the Phys., Am. Coll. Fla. Chap. ratology, Soc. of al Officers', Soc. of al Medicine s & Gynec. Society diedic Society toedic Society toedic Society toedic Society Med. & Rehabil., Fla. Soc. al & Reconstr. Surg. blogic Society atric Society clogical Soci	A. Mackenzie Manson, Jack'ville Jack R. Rudolph, Miami George H. Mix, Lakeland Dwight J. Wharton, Jack'ville Stuart C. Smith, Tallahassee Ray. E. Kaufman, Lake Worth Miles J. Bielek, Ft. Lauderdale Sam W. Denham, Jacksonville J. Brown Farrior, Tampa Lyle W. Russell, Miami W. Ansell Derrick, Orlando John H. Cordes Jr., St. Petersburg	Charles H. Burke, Jacksonville Walter L. Schafer, St. Petersburg James T. Atkins, Jacksonville Nelson H. Kraeft, Tallahassee William H. Eyster Jr., Daytona B. Wm. F. Hill Jr., Sebring Lawrence E. Geeslin, Jacksonville Davis H. Vaughan, Clearwater Bernard M. Barrett, Pensacola George I. Raybin, Jacksonville Sanford A. Mullen, Jacksonville	Hollywood (Specialty Group meetings are scheduled Association)
s Science Exam. Board Banks, Association Cross of Florida, Inc. Shield of Florida, Inc. In Council tes Association I Society, State Association of Medical Examiners Association accutical Assn., State Health, Association cic Society rulosis & Health Assn. In's Auxiliary can Medical Association	Fred J. Woods, Tampa Mr. C. DeWitt Miller, Orlando W. Dean Steward, Orlando W. Dean Steward, Orlando Joseph J. Zavertnik, Miami James B. Tobias, St. Petersburg Richard C. Chace, Orlando Paul N. Unger, Miami Beach Middleton T. Mustian, Gainesville Alpheus T. Kennedy, Pensacola Mrs. Idalyne Lawhon, Tampa Dan H. Davis, Ft. Lauderdale Carolyn Roth, Jacksonville Allen L. Armstrong, Tampa	M. W. Emmel, Gainesville Mrs. A. B. Del Valle, Tampa Mr. H. A. Schroder, Jacksonville John T. Stage, Jacksonville James E. Fulghum, Jacksonville George F. Schmitt Jr., Miami J. Leon Schwartz, Tampa Louis Lemberg, Miami Willie G. Hinson, Marianna Homer L. Pearson Jr., Miami Mrs. Maurine Finney, Miami Mrs. Q. Richards, Ft. Myers Mr. Everett H. Williams Jr., Jax. David M. Travis, Gainesville Tom S. Coldewey, Port St. Joe Mrs. Roger E. Phillips, Orlando	Hollywood, May 6-10, '64 Tampa, Nov. 16, '63 Miami Beach, Oct. '63 Miami Beach, May 24-27, '64 Orlando, Oct. 10-12, '63 Orlando, Apr. 23, '64 Hollywood, May 6-10, '64 San Francisco, June 21-25, '64
AI.A. Clinical Session	Daniel L. Sexton, St. Louis	Robert F. Butts, Birmingham	Portland, Ore., Dec. 1-4, '63 New Orleans, Nov. 18-21, '63



P. L. DODGE MEMORIAL HOSPITAL

formerly

MIAMI MEDICAL CENTER

M. G. ISAACSON, M.D. Medical Director and President

1861 N.W. South River Drive Phone 379-1448

A private institution for the treatment of nerrous and mental disorders and the problems of
drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including — Psychotherapy, Insulin, & Electroshock,
when indicated. Adequate facilities for recreation and out-door activities.

Information on request
Member NAPPH and American Psychiatric Assn.

County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL D	FOTAL MEMBERS Associate Active
Alachua	Billy Brashear, Gainesville	Carl E. Van Arnam, Gainesville	2nd Tues.	16	114
"Bradjord, Guenrist, Union Bay Brevard Broward Charlotte Clay Collier	A. Ralph Monaco, Panama City Albert F. Stratton Jr., Cocoa Gordon B. Carver, Fort Lauderdale Stephen R. Roddy, Punta Gorda Hinson L. Stephens, Orange Park John C. Garland, Naples Frank E. Adel, Lake City	Owen Reese Jr., Panama City Adrian R. Jensen, Rockledge Yale Citrin, Hollywood Arno von Ruckteschell, Punta Gorda Aubrey Y. Covington, Green Cove Spgs. Ethel H. Trygstad, Naples Barney E. McRae Jr., Lake City	1st Tues. 1st Tues. 4th Tues. 2nd Tues. 4th Tues. 3rd Wed.	25 0 0 1	33 106 325 10 7 17
*Baker Dade DeSoto-Hardee-Glades DeSoto-Hardee-Glades Duval Escambia Franklin-Gulf Gadsden-Liberty Highlands Hilsborough Indian River Jackson-Calhoun Lake Lee-Hendry Leon-Wakulla-Jefferson Madison Maratee	Julius Alexander, Miami James R. Whitehurst, Bowling Green Hugh A. Carithers, Jacksonville Gerald H. Hilbert, Pensacola Photis J. Nichols, Apalachicola J. Lloyd Massey, Quincy Burton C. Ostling, Avon Park Marshall E. Smith, Tampa Donald D. Gold, Vero Beach Jabe A. Breland, Marianna H. Durham Young Jr., Leesburg Charles E. Peres Jr., Fort Myers David J. McCulloch, Tallahassee Thomas G. Bouland Jr., Madison Joseph B. Ganey, Bradenton Harry S. Gibboney Jr., Ocala	Richard C. Clay, Miami Malcolm M. Sayre, Wauchula Richard T. Shaar, Jacksonville Leonard F. Hattaway, Pensacola William F. Wager, Port St. Joe Gene T. Blakely, Quincy C. Brooks Henderson, Avon Park Frank A. Massari, Tampa E. B. Hardee Jr., Vero Beach Francis M. Watson, Marianna Argin A. Boggus Jr., Tavares Roy S. Giles, Fort Myers James K. Conn, Tallahassee Royce V. Jackson, Madison Angus W. Graham Jr., Bradenton Alexander Goulard Jr., Ocala	lst Tues. lst Tues. lst Tues. lst Tues. 2nd Tues. Last Wed. Quarterly 3rd Mon. lst Tues. 2nd Tues. 2nd Tues. 3rd Mon. lst Wed. lst Wed. lst Wed. 3rd Mon. lst Tues. 2nd Tues. 3rd Tues.	152 152 41 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1,185 17 364 122 122 17 20 293 19 17 40 51 76 55 35
*Levy Monroe Nassau Carage	Philip R. Dobert, Key West Benjamin F. Dickens, Fernandina Bch. Charles R. Sias, Orlando	Elmer J. Eisenbarth, Key West Daniel M. Jacobs Jr., Fernandina Bch. Truett H. Frazier, Orlando	1st Thurs. 1st Thurs. 3rd Wed.	1 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	26 9 259
* Osceola Palm Beach Pasco-Hernando-Citrus	Samuel A. Manalan, W. Palm Beach Dwayne L. Deal, Dade City	Nicholas S. Petkas, West Palm Beach W. Wardlaw Jones, Dade City	4th Mon. 2nd Thurs.	13	240 22
Pinellas Polk Putnam St. Johns St. Lucie-Okeechobee-Martin Sarasota Seminole Suwannee-Hamilton-Lafayette Taylor	John P. Ferrell, St. Petersburg Paul E. Coury, Lakeland Charles E. Barrineau, Palatka James J. DeVito, St. Augustine Melvin Wokowsky, Fort Pierce Douglas R. Murphy, Venice Edwin L. Lindsey, Sanford Charles R. Wiley, Perry	William J. Dean, St. Petersburg Albert G. King Jr., Lakeland James R. Sayers, Palatka William W. O'Connell, St. Augustine George Theodorou, Fort Pierce Rudolph C. Garber Jr., Sarasota John T. Johnson, Sanford James F. Dietrich, Live Oak John A. Dyal Jr., Perry	lst Mon. 2nd Wed. 2nd Tues. 3rd Tues. 2nd Tues. 2nd Tues. 2nd Tues. 1st Sat. Last Fri.	42 11 0 0 15 0 0	358 158 15 19 39 203 21 5
Volusia *Flaaler	Carroll M. Crouch, Daytona Beach	Michael R. Blais, Daytona Beach	2nd Tues.	5	111
Walton-Okaloosa-Santa Rosa Washington-Holmes	-Hiram M. Melvin, Milton Ralph H. Segrest, Bonifay	Elbert W. Sutton, Pace Jimmy F. Henry, Chipley	3rd Tues. Quarterly Total	0 0 448	39 5 4,487

FLORIDA MEDICAL ASSOCIATION OFFICERS, COUNCILS AND COMMITTEES

OFFICERS	COUNCIL ON ALLIED PROFESSIONS
WARREN W. QUILLIAN, M.D., President	THOMAS C. KENASTON SR., M.D., Chm
EXECUTIVE DIRECTOR	X-Ray Technicians—RAYMOND E. PARKS, M.D., Chm. 64
W. HAROLD PARHAMJacksonville	JUDICIAL COUNCIL
	JERE W. ANNIS, M.D., Chm. Lakeland
BOARD OF GOVERNORS	ARCHIVES
WARREN W. QUILLIAN, M.D.,* Chm., Ex Officio	CLII-FORD C. SNYDER, M.D., Chm. D-66 WILLIAM M. STRAIGHT, M.D. AL-64 . Miami GEORGE W. MORSE, M.D. A-67 Pensacola W. WARDLAW JONES, M.D. B-65 Dade City HUGH WEST, M.D. C-64 Coral Gables Miami Pensacola Dade City DeLand
H. PHILLIP HAMPTON, M.D., (Vice President) Ex Officio	GRIEVANCE
EUGENE G. PEEK JR., M.D., (Speaker of the House) Ex OfficioOcala ELOYD K. HURT, M.D.,* (Secretary-Treasurer) Ex OfficioJacksonville ROBERT E. ZELLNER, M.D.*PP-65Orlando	JERE W. ANNIS, M.D., Chm. RALPH W. JACK, M.D. LEO M. WACHTEL, M.D. S. CARNES HARVARD, M.D. ROBERT E. ZELLNER, M.D. Orlando
S. CARNES HARVARD, M.D.*PP-64Brooksville JACK Q. CLEVELAND, M.DAL-64Coral Gables HENRY J. BABERS JR., M.DA-66Gainesville EDWARD L. COLE JR., M.DB-67St. Petersburg CHAS. J. COLLINS, M.DC-65Orlando	MEDICAL LICENSURE HOMER L. PEARSON JR., M.D., Chm. ALPHEUS T. KENNEDY, M.D. JOSEPH S. STEWART, M.D. AL-64 Miami
RALPH S. SAPPENFIELD, M.D. D-64Miami REUBEN B. CHRISMAN JR.,	MEMBERSHIP AND DISCIPLINE
M.DAMA Delegate-64Coral Gables LEO M. WACHTEL, M.DSBH-64Jacksonville *Executive Committee †Public Relations Officer Subcommittees:	District 1—SIDNEY G. KENNEDY JR., M.D. 66 Pensacola WILLIAM C. ROBERTS, M.D. 67 Panama City 2—ASHBEL C. WILLIAMS, M.D. 66 Jacksonville RAYMOND H. KING, M.D. 64 Jacksonville JOHN R. HILSENBECK, M.D. 66 Miami 10HN R. HILSENBECK, M.D. 66 Miami NELSON ZIVITZ, M.D. 64 Miami Beach District 5—W. WARDLAW JONES, M.D. 64 Dade City LOHN I CHELEDEN M.D. 66 Dade City LOHN I CHELEDEN M.D. 66 Dade City Beach
Florida Medical Foundation	
EDWARD JELKS, M.D. Jacksonville Inter-American Relations JOHN T. KILPATRICK, M.D., Chm. Miami FRANKLIN J. EVANS, M.D. Coral Gables RALPH S. SAPPENFIELD, M.D. Miami RICHARD F. STOVER, M.D. Miami WILLIAM B. WELCH, M.D. Miami	District 6—WILLIAM H. PROCTOR, M.D. 66 MILES J. BIELEK, M.D. 67 District 7—JOHN M. BUTCHER, M.D.—66 GORDON H. McSWAIN, M.D., Chm. 67 District 8—THOMAS H. BATES, M.D. 64 WILLIAM C. THOMAS SR., M.D. 65 Gaincsville
Quackery EDWARD L. COLL JR., M.D., Chm. St. Petersburg CHARLES R. SIAS, M.D. Orlando JUJIUS ALEXANDER, M.D. Miami IRVING E. HALL JR., M.D. Bradenton WILLIAM C. ROBERTS, M.D. Panama City	M.D. 65 District 9—JAMES T. COOK, M.D. 65 GEORGE H. GARMANY, M.D. 67 District 10—ERNEST R. BOURKARD, M.D. 64 C. FRANK CHUNN, M.D. 65 District 11—THOMAS C. KENASTON SR., M.D. 65 FRANK C. BONE, M.D. 67 District 12—EDWARD L. COLE JR., M.D. 65 St. Petersburg
Venomous Snake Bite NEWTON C. McCOLLOUGH, M.D., Chm. C-65 Orlando	N. WORTH GABLE, M.D. 64 St. Petersburg COUNCIL MEMBER FROM BOARD OF
CARL E. ANDREWS, M.D. AL-64 West Palm Beach RAY O. EDWARDS JR., M.D. A-67 Jacksonvillz KENNETH W. JACKSON, M.D. B-64 Lake Alfred JOHN E. DEES, M.D. D-66 Miami	PAST PRESIDENTS 110 M. WACHTEL, M.D. Jacksonville

COUNCIL ON LEGISLATION AND PUBLIC AGENCIES

H. PHILLIP HAMPTON, M.D., Chm. Tampa

STATE LEGISLATION

GEORGE S. PALMER, M.D., ChmAL-64	
EUGENE G. PEEK JR., M.D. A-66	Ocala
JOHN E. OREBAUGH, M.D. B-67 St.	Petersburg
WALTER J. GLENN IR., M.D., C-65 Fort	Landerdale
EDWARD R. ANNIS, M.D D-64	Miami
EDWARD R. ANNIS, M.D., D-64 EDWARD JELKS, M.D., Advisory	lacksonville
Subcommittee	,
Liaison with State Agencies	
FRANCIS T. HOLLAND, M.D., Chm	Tallahassee
PAUL S. JARRETT, M.D., Alcoholic Rehabilitation	
EUGENE G. PEEK JR., M.D., SBH	Ocala
GEORGE S. PALMER, M.D.,	Ocuia
Children's Commission	Tallahassee
MARION W. HESTER, M.D.,	1 allanassee
Council for the Blind	Lakeland
FRANCIS T. HOLLAND, M.D.,	Luketana
Crippled Children's Commission	Tallahassee
CHARLOTTE C. MAGUIRE, M.D.,	1 anamassee
Division of Child Training	Orlando
	Grianao
RAYMOND J. FITZPATRICK, M.D.,	C -::11-
Division of Correction	_Gainesville
ZACK RUSS JR., M.D., Division of Mental Health	Tampa
IRVING E. HALL JR., M.D., Education Dept	Bradenton
THOMAS J. BIXLER, M.D.,	
	Tallahassee
	Lakeland
CHARLES K. DONEGAN, M.D.,	
	. Petershurg
GEORGE H. McSWAIN, M.D.,	
Vocational Rehabilitation Da	ytona Beach

NATIONAL LEGISLATION

H. PHILLIP HAMPTON, M.D., Chm.	Tampa
Subcommittee	·
Liaison with Federal Agencies	
ROY E. CAMPBELL, M.D., Chm	Palatka
BURNS A. DOBBINS JR., M.D.,	
Department of Defense	Fort Lauderdale
JERE W. ANNIS, M.D., Department of	
Health, Education and Welfare	Lakeland
ROBERT H. MICKLER, M.D., Dept. of Justice	Tallahassee
THOMAS J. BIXLER, M.D., Dept. of Labor	Tallahassee
ROY E. CAMPBELL, M.D., Department of	
Veterans Administration	Palatha

COUNCIL ON MEDICAL ECONOMICS

BURNS A. DOBBINS JR., M.D. Chm. Fort Lauderdale

ADVISORY TO BLUE SHIELD

JACK A. MaCRIS, M.D., Chm. B-66	St. Petersburg
JAMES D. BEESON, M.D. AL-64	Jacksonville
JOHN W. HENDRIX, M.D.,A-64	Port St. Joe
C. MERRILL WHORTON, M.DA-67	Jacksonville
EARL G. WOLF, M.DA-65	Pensacola
RAYMOND J. FITZPATRICK, M.DA-66	Gainesville
IRVING M. ESSRIG, M.D. B-64	
THOMAS W. DORR, M.D.—B-65	Tampa
HENRY G. MORTON, M.D. B-67	
CHARLES R. SIAS, M.DC-64	Orlando
CARL S. McLEMORE, M.D C-65	
JOHN R. MAHONEY, M.DC-66	Fort Lauderdale
LEE M. SPIVEY, M.D C-67	
FRANK G. WILSON, M.D. D-64	
GEORGE S. BALDRY, M.D. D-65	Miami
WILEY M. SAMS, M.D D-66	
JAMES L. ANDERSON, M.D D-67	

COMMERCIAL HEALTH INSURANCE

DUNCAN T. McEWAN, M.D., ChmAL-64	Orlando
JOHN H. TERRY, M.DA-64	Jacksonville
WILLIAM H. KEELER III, M.DB-67	St. Petersburg
DAVID I. LEHMAN JR., M.D C-66	- Hollywood
JACK KEEFE III, M.D. D-65	. Miami

FEE SCHEDULES

HENRY J. BABERS JR., M.D., ChmA-66	Gainesville
NEWTON C. McCOLLOUGH, M.DAL-64	
HENRY L. HARRELL, M.D. A-65	
PAUL J. McCLOSKEY, M.D B-67	Татра
WILLIAM J. DEAN, M.D. B-66	t. Petersburg
BURNS A. DOBBINS JR., M.D. C-64 For	t Lauderdale
JAMES F. COONEY, M.DC-67	
RALPH S. SAPPENFIELD, M.D. D-64	Miami
OLIVER P. WINSLOW IR., M.D., D-65	- Miami

INDUSTRIAL MEDICINE

NEWTON C. McCOLLOUGH, M.D., ChmAL-64	Orlando
P. G. BATSON JR., M.D. A-65	Pensacola
CHARLES LARSEN JR., M.D. B-66	Lakeland
LLOYD J. NETTO, M.D. C-64West P	alm Beach
TRUXTON L. JACKSON, M.D. D-67	Miami

MEMBERS INSURANCE

H. CLINTON DAVIS, M.D., Chm. D-66	Miami
H. LAWRENCE SMITH, M.DAL-64	
FLOYD K. HURT, M.D., A-64	
WILLIS W. HARRIS, M.D. B-67	Bradenton
BENNETT J. LACOUR JR., M.D	Daytona Beach

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

HUGH A. CARITHERS, M.D., Chm. Jacksonville

HOSPITALS

JOHN S. STEWART, M.D., ChmB-67	Fort Myers
ALBERT F. STRATTON JR., M.D. AL-64	Cocoa
RAYMOND B. SQUIRES, M.D. A-65	Pensacola
WALTER J. GLENN JR., M.D. C-64Fo	ort Landerdale
ROBERT F. DICKEY, M.D. D-66	Miami

INTERNSHIPS AND RESIDENCIES

HUGH A.	CARITHERS, M.D., ChmA-	65Jacksonville
WILLIAM	H. PROCTOR, M.D. AL-64	West Palm Beach
EDWARD	L. COLE JR., M.D B-66	St. Petersburg
ACHILLE	A. MONACO, M.DC-64	Daytona Beach
WILLIAM	M. STRAIGHT, M.D. D-67	Miami

MEDICAL SCHOOLS

EDWARD W. CULLIPHER, M.D., Chm I	0-66
Dade County Medical Assn.	
MILTON M. COPLAN, M.D. AL-64	Miami
J. MAXEY DELL JR., M.DA-67	
Alachua County Medical Society	
C. FRANK CHUNN, M.D. B-65	
CHAS. J. COLLINS, M.D., C-64	Orlando
HAYDEN C. NICHOLSON, M.D.,	
Faculty, U. of Miami	Miami
GEORGE T. HARRELL, M.D.,	
Faculty, U. of Florida	Gainesville

PHYSICIAN PLACEMENT

JAMES T. COOK, M.D., ChmA-67	Marianna
MELVIN M. SIMMONS, M.D. AL-64	Sarasota
ARTHUR J. WALLACE, M.D B-66	Татра
DAVID W. GODDARD, M.DC-65	Daytona Beach
HOMER L. PEARSON JR., M.DD-64	Miami

COUNCIL ON MEDICAL SERVICES

CHARLES R. SIAS, M.D., Chm. Orlando

AGING

WILLIAM R. DANIEL, M.D., Chm. AL-64 Orlando
CHARLES J. KAHN, M.D. A-66 Pensacola
IAMES A. WINSLOW JR., M.D. B-65Tampa
LOUIS L. AMATO, M.D. C-64 Fort Landerdale
CARLOS P. LAMAR, M.D. D-67 Miami

BLOOD

	coa_Beach
	Palatka
GERARD H. HILBERT, M.D. A-66	Pensacola
JAMES N. PATTERSON, M.D. B-65	Tampa
O. WHITMORE BURTNER, M.D. D-64	Miami

CHILD HEALTH

IRVING E. HALL JR., M.D., ChmB-64	. Bradenton
ADRIAN O. POLLOCK, M.D. AL-64	Fort Myers
RICHARD G. SKINNER JR., M.DA-65	Jacksonrille
ANDREW W. TOWNES, M.DC-67	Orlando
WESLEY S. NOCK, M.DD-66	Coral Gables

EMERGENCY MEDICAL SERVICE

JAMES L. CAMPBELL JR., M.D., Chm	. Orlando
ALPHEUS T. KENNEDY, M.D. AL-64	Pensacola
SAMUEL J. ALFORD JR., M.DA-64	Jacksonville
IOHN M. BUTCHER, M.D. B-64	Sarasota
JOSEPH S. STEWART, M.D. D-64	Miami

HEARING

G. DEKLE TAYLOR, M.D., Chm. A-66
GEORGE T. SINGLETON, M.D. AL-64
J. BROWN FARRIOR, M.D. B-65
JOHN H. WEBB JR., M.D. C-64
Orlando
JAMES R. CHANDLER, JR., M.D. D-67
Miami

SCIENTIFIC WORK

RICHARD C. DEVER, M.D., Chm. D-66
RICHARD T. SMITH, M.D. AL-64
THAD MOSELEY, M.D. A-64
CHARLES H. LASLEY, M.D. B-67
OSCAR W. FREEMAN, M.D. C-65
Miaml
Gainesville
Jacksonville
Clearwater
OF Charles
Orlando

INDIGENT CARE

NELSON ZIVITZ, M.D., Chm. D-65
ROBERT L. TOLLE, M.D. Al-64
EDWARD JELKS, M.D. A-64
EBNJAMIN J. MEADOWS JR., M.D. B-67
JOHN J. CHELEDEN, M.D. C-66

Miani Beach
Orlando
Jacksonville
Tampa
Daytona Beach

COUNCIL ON SPECIAL ACTIVITIES

WALTER C. PAYNE SR., M.D., Chm. Pensaeola

LABOR

THEODORE J. KAMINSKI, M.D., Chm. C-66 Melbourne LAURENT P. LaROCHE, M.D. AL-64 Cocoa Beach PAUL F. BARANCO, M.D. A-64 Pensacola GEORGE J. SUAREZ, M.D. B-67 Tampa EDWARD R. ANNIS, M.D. D-65 Miami

ADVISORY TO WOMAN'S AUXILIARY

GORDON H. IRA, M.D., Chm... A-67. Jacksonville W. DEAN STEWARD, M.D. AL-64 Orlando FUGENE B. MAXWELL, M.D. B-65 Tampa LEE ROGERS JR., M.D. C-64 Cocoa DONALD F. MARION, M.D. D-66 Miami

MATERNAL HEALTH

JAMES M. INGRAM, M.D., Chm. AL-64
JOSEPH W. DOUGLAS, M.D. A-66
S. L. WATSON, M.D. B-64
JAMES R. SORY, M.D. C-65
William T. MIXSON JR., M.D. D-67
West Palm Beach
Coral Gables

BOARD OF PAST PRESIDENTS

WALTER C. PAYNE SR., M.D., Chm., 194	9 Pensacola
ROBERT E. ZELLNER, M.D., Seey., 1962	Orlando
FREDERICK J. WAAS, M.D., 1928	Jacksonville
WILLIAM M. ROWLETT, M.D., 1933	Tampa
HOMER L. PEARSON JR., M.D., 1934	Miami
ORION O. FEASTER, M.D., 1936	Long Beach, Miss.
EDWARD JELKS, M.D., 1937	Jacksonville
LEIGH F. ROBINSON, M.D., 1939	Fort Lauderdale
WALTER C. JONES, M.D., 1941	Miami
EUGENE G. PEEK SR., M.D., 1943	Ocala
SHALER RICHARDSON, M.D., 1946	Jacksonville
WILLIAM C. THOMAS SR., M.D., 1947	
	Miami
	St. Augustine
	Tampa
	Jacksonville
	West Palm Beach
DUNCAN T. McEWAN, M.D., 1954	
JOHN D. MILTON, M.D., 1955	
FRANCIS H. LANGLEY, M.D., 1956	
WILLLIAM C. ROBERTS, M.D., 1957	
JERE W. ANNIS, M.D., 1958	
RALPH W. JACK, M.D., 1959	
LEO M. WACHTEL, M.D., 1960	
S. CARNES HARVARD, M. D., 1961	Brooksville

MENTAL HEALTH

ZACK RUSS JR., M.D., Chm. B-65
WILLIAM M. C. WILHOIT, M.D. AL-64
JOHN A. RITCHIE, M.D. A-66
Jacksonville
JAMES W. ETTINGER, M.D. C-64
EDWARD H. WILLIAMS, M.D. D-67

Zampa

Tampa
Pensacola
Jacksonville
Rockledge
Coral Gables

PUBLIC HEALTH

CHARLES R. SIAS, M.D., Chm. AL-64
SIMON D. DOFF, M.D. A-65
LEFFIE M. CARLTON JR., M.D. B-67
CLARENCE L. BRUMBACK, M.D. C-64
JOHN D. MILTON, M.D. D-66

CHARLES R. SIAS, M.D., Chm. AL-64
Jacksonville
Tampa
West Palm Beach
Miami

A.M.A. HOUSE OF DELEGATES

REUBEN B. CHRISMAN IR., M.D.,
Chm., DelegateCoral Gables
ROBERT E. ZELLNER, M.D., Alternate. Orlando
(Terms expire Dec. 31, 1964)
FRANCIS T. HOLLAND, M.D., Delegate Tallahassee
MADISON R. POPE, M.D., Alternate Plant City
(Terms expire Dec. 31, 1964)
JERE W. ANNIS, M.D., Delegate Lakeland
LEO M. WACHTEL, M.D., Alternate Jacksonville
(Terms expire Dec. 31, 1964)
MEREDITH MALLORY, M.D., Delegate Orlando
EUGENE G. PEEK JR., M.D., Alternate Ocala
(Terms expire Dec. 31, 1963)
BURNS A. DOBBINS JR., M.D., Delegate _ Fort Lauderdale
WALTER E. MURPHREE, M.D., Alternate Gainesville
(Terms expire Dec. 31, 1963)

RURAL HEALTH

J. BASIL HALL, M.D., Chm. C-66 Tavares
DONALD C. HARTWELL, M.D., AL-64 Avon Park
GEORGE W. KARELAS, M.D., A-64 Newberry
FORREST HINTON, M.D., B-67 Immokalee
ELMER J. FISENBARTH, M.D., D-65 Marathon

VISION

CURTIS D. BENTON JR.,
M.D., Chm. C-65

MARION W. HESTER, M.D. AL-64
THOMAS S. EDWARDS, M.D. A-67
JOSEPH W. TAYLOR JR., M.D. B-66
KENNETH S. WHITMER, M.D. D 64

Curtis D. Benton JR.,
Fort Lauderdale
Lakeland
Jacksonville
Tampa
KENNETH S. WHITMER, M.D. D 64

SCIENTIFIC COUNCIL

THAD MOSELEY, M.D., Chm. -

THE JOURNAL AND OTHER PUBLICATIONS

THAD MOSELEY, M.D., Editor
SHALER RICHARDSON, M.D., Editor Emeritus
FRANZ II. STEWART, M.D., Assistant Editor
CHARLES K. DONEGAN, M.D.,
Assistant Editor
JOHN M. PACKARD, M.D., Assistant Editor
Fensacola

POSTGRADUATE EDUCATION

CHAS. J. COLLINS, M.D., Chm. C-65 Orlando ALBERT G. KING JR., M.D. AL-64 Laketa d WILLIAM C. THOMAS JR., M.D. A-67 Gainesville RICHARD G. CONNAR, M.D. B-66 Tampa JOHN V. HANDWERKER JR., M.D. D-64 Miami

RESEARCH

KARL B. HANSON, M.D., Chm. A
DONALD W. SMITH, M.D. AL
MILLARD B. WHITE, M.D. B
Sarasota
MARTIN G. GOULD, M.D. C
JAMES J. GRIFFITTS, M.D. D
Miami

COUNCIL ON SPECIALTY MEDICINE

Jacksonville
_ Jacksonville
Jacksonville
Jacksonville
Tallahassee
Daytona Beach
Tampa
Orlando
Miami
Jacksonville
Jacksonville
Jacksonville

ychiatry MAREIN C. MOORE, M.D., 1967	Jacksonville
diology IVAN ISAACS, M.D., 1964	Jacksonville
rgery EMMET F. TERGUSON JR., M.D., 1966	Jacksonville
ology DAVID W. GODDARD, M.D., 1966	Daytona Beach
Subcommittee on Specialty Groups	
CHARLES H. BURKE, M.D.	Jacksonville
Florido Acodemy of General Practice WALTER L. SCHAFER, M.D.	St. Petersburg
Florida Allergy Society JAMES T. ATKINS, M.D.	Jacksonville
Florido Society of Ancsthesiologists NELSON II. KRAEFT, M.D.	Tallahassee
Florida Chapter, American College of WILLIAM H. EYSTER JR., M.D.	Chest Physicians Daytona Beach
WILLIAM F. HILL IR., M.D.	Sebring
LAWRENCE E. GEESLIN, M.D.	Jacksonville
Florida Society of Internal Medicine DAVIS II. VAUGHAN, M.D.	Clearwater
DAVIS II. VAUGHAN, M.D. Florido Society of Obstetrics and Gyne BERNARD M. BARRETT, M.D.	Pensacola
GEORGE 1. RAYBIN, M.D.	Otoloryngology Iacksonville
SANIORD A. MULLEN, M.D.	lacksonville
Florida Society of Pathologists OLIVER F. DEEN JR., M.D.	Татра
Florida Pediotrie Society W. C. FLEMING, M.D.	Coral Gables
Florido Society of Physical Medicine a JOHN M. HAMILTON, M.D.	nd Rehabilitation St. Petershore
Florido Society of Plastic and Reconstr	uctive Surgery
JOHN R. BUTTER, M.D Florida Proctologic Society WILLIAM C. RUFFIN JR., M.D.	Gainesville
Florida Psychiotric Society DAVID KIRSH, M.D.	Miami
Florido Radiological Society HARRY W. REINSTINE JR., M.D.	
Florida Chapter, American College of S JOHN H. TERRY, M.D.	urgeons
Florido Association of General Surgeon FRED II. ALBEE JR., M.D.	S
Florida State Surgical Div., Int'l Colleg	Daytona Beach e of Surgeons Jacksonville
Florida Urological Society	jacksonville

COUNCIL ON VOLUNTARY HEALTH AGENCIES

MASON ROMAINE III, M.D., Chm.	Jacksonville
MASON ROMAINE HI, M.D. Florida Heart Association	Jacksonville
WOODS A. HOWARD, M.D. Arthritis and Rheumatism Foundation	Lakeland
CHARLOTTE C. MAGUIRE, M.D.	Orlando
Fla. Society for Crippled Children and Adults EARL E. WILKISON, M.D. Fla. Division, American Cancer Society	Tallahassee
FRANK L. CREEL, M.D.	Pensacola
Florida Association for Mental Health HAWLEY H. SEILER, M.D. Florida TB and Health Association	Tampa
RICHARD G. SKINNER JR., M.D. National Foundation	Jacksonville
THOMAS S. EDWARDS, M.D Florida Society for Prevention of Blindness	Jacks) vill

FLORIDA MEDICAL FOUNDATION

EO M. WACHTEL, M D., Pres.	Jacksonville
CARNES HARVARD, M.D., Vice Pres.	Brooksville
ENRY J. BABERS JR., M.D., Secy-Treas.	Gainesville

INVESTMENT TRUST COMMITTEE

LICYD K. HURT, M.D., Chm.	Jacksonville
SAMUEL M. DAY, M.D.	lacksonville
BURNS A. DOBBÍNS JR., M.D.	Fort Lauderdale
SHERMAN B. FORBES, M.D.	- Tamra
EDWARD JELKS, M.D.	Jacksonville
NORVAL M. MARR SR., M.D.	- St. Petersburg
CARL S. McLEMORE, M.D.	Orlando
JOHN D. MILTON, M.D.	- Coral Gables
WILLIAM M. C. WILHOIT, M.D.	Pensacola

LEGAL COUNSEL

MARKS, GRAY, YATES, CONROY & GIBBS lacksonville

CERTIFIED PUBLIC ACCOUNTANTS

LUCAS AND HERNDON Jacksonville

from confusion and apathy ...

... to Clarity and Interest Cerebro-

A safe effective cerebral stimulant and vasodilator for your forgetful aging patient. On Cerebro-Nicin therapy, your patient shows improvement in social activity and relationships, and greater concern with personal appearance.

FORMULA:

PTZ (Pentamethylene

Tetrazole)	.100 mg
Nicotinic Acid	100 mg
Niacinamide	. 5 mg
Vitamin C	100 mg
Thiamine HCI	. 25 mg
Riboflavin	. 2 mg
Pyridoxine	
1-Glutamic Acid	50 mg

INDICATIONS: Apathy, dizzy spells, mild behavior disorders, mental confusion, functional memory defects.

AVERAGE DOSE: One capsule three

AVAILABLE: Bottles of 100 and 500

CAUTION: Most persons experience a flushing and tingling sensation after taking a higher potency niacincontaining compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause for discontinuance of the drug if the patient is forewarned to expect the reaction.

WARNING: Contraindicated in the presence of epilepsy.



Write for samples and literature... THE BROWN PHARMACEUTICAL COMPANY 2500 West Sixth Street, Los Angeles 57, California

Ps

RaSu Ur



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

- 1. A sprain or fracture is not a big clinical problem but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.
- 2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.
- 3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness ("numbs the pain...not the patient").

- 4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.
- 5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma Compound



carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning-may be habit forming.)

Wallace Laboratories / Cranbury, N. J.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillory or venous bleeding presents a problem.

KOAGAMIN has on outstanding safety record -- in 25 years of use no report of on untoword reaction hos been received: however.

> it should be used with core on potients



parenteral hemostat

Each cc contains: 5 mg. oxolic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium corbonote os buffer. Camplete data with each 10cc vial. Theropy chart on request.



(hatham) CHATHAM PHARMACEUTICALS, INC.

Newark 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario

INDEX TO ADVERTISERS

• Ames Co., Inc.	Third C	Cover
Anclote Manor		98
Anderson Surgical Supply Co		96
Appalachian Hall		
Arnar-Stone Laboratories	~~~~~	91
Ballast Point Manor		88
Brawner Hospital, Inc		78
Brown Pharmaceutical Co	~~~~	104
Burroughs Wellcome & Co		7, 87
• Chatham Pharmaceuticals, Inc		106
Convention Press		
Dorsey Laboratories		82
Duvall Home		78
• Endo Laboratories	8 8 8 8 8 7 7 7 7 8 8 8 7 7 7 7 7 7 7 7	86
• J. H. Filbert, Inc		97
Glenbrook Laboratories		8, 12
Guild of Prescription Opticians		90
Highland Hospital, Inc		
Hill Crest Sanitarium		92
• Johnson & Johnson		10a
Lederle Laboratories		
• Eli Lilly & Co.		
Medical Protective Co		
Medical Supply Co		92
• Parke Davis & Co		
Physicians Products Co		75
• P. L. Dodge Memorial Hospital		
• PM of Florida		
• Wm. P. Poythress & Co., Inc.		
• A. H. Robins Co., Inc.		
• Roche Laboratories		
Saron Pharmacal Corp		
• Schering Corp.		
G. D. Searle Company		
• Smith, Kline & French		
• E. R. Squibb & Sons		
Surgical Supply Co		
• Tucker Hospital, Inc.		
• U. S. Vitamin & Pharmaceutical		
Wallace Laboratories		
Winthrop Laboratories		
• Zeigler of Florida		98

neither **tension**, nor **spasm**,
nor **stasis**stays this patient
from his
appointed rounds



DECHOLIN-BB

.... especially when UPPER G.I. COMPLAINTS have biliary implications

for nervous tension Each Tablet Contains:

WARNING: May be habit forming

for smooth-muscle spasm

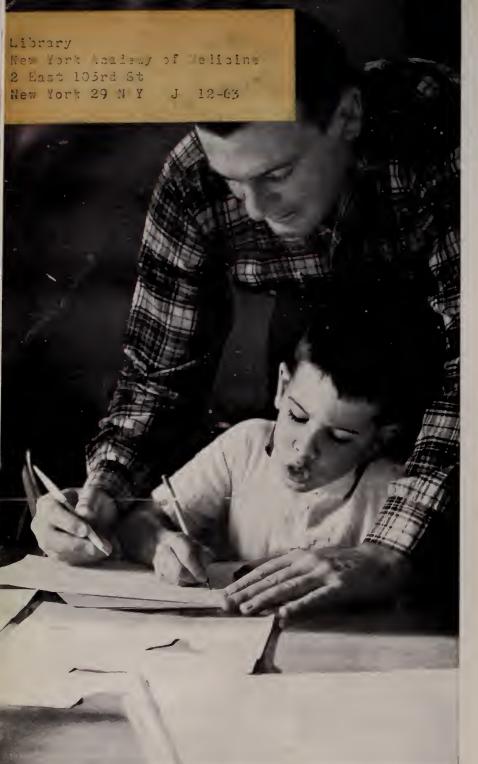
BELLADONNA EXTRACT

for biliary/intestinal stasis

DEHYDROGUOLIG AGID
250 mg, 63% gr.l.

Average adult dose: 1 or, if necessary, 2 tahlets three times daily. Precautions: Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction; caution drivers against possible drowsiness. Side effects: Dehydrocholic acid may cause transitory diarrhea; belladonna may cause blurred vision and dry mouth. Contraindications: Biliary tract obstruction, acute hepatitis, glaucoma, prostatic hypertrophy. Available: DECHOLIN-BB, bottles of 100 tablets. Also: DECHOLIN® with Belladonna (dehydrocholic acid, 250 mg.), bottles of 100 and 500 tablets.





anxiety and tension relieved alertness maintained

Librium[®] (chlordiazepoxide HCl)

the successor to the tranquilizers



Formerly nervous and tense, now better able to...

enjoy hi childrer

This, in essence, is what happens whe place a patient on Librium (chlordiaz ide HCl). Since this agent generally re anxiety and tension without dulling n clarity or inducing drowsiness, most pa become better able to function non take an active interest in family and roundings, meet and solve daily prot This antianxiety agent is virtually free extrapyramidal side effects, and doe produce or deepen depression.

Dosage: Oral – Usual adult dose in mild to modera ety and tension is 5 or 10 mg, 3 or 4 times daily; in anxiety and tension, 20 or 25 mg, 3 or 4 time Parenteral - To control acute conditions, the usu adult dose is 50 to 100 mg I.M. or I.V.; not m 300 mg should be given during a 6-hour period. effects: Oral-Drowsiness and ataxia, usually dose have been reported in some patients - particul elderly and debilitated. Paradoxical reactions, i.e ment, stimulation, elevation of affect and acute ra been reported in psychiatric patients; these react be secondary to relief of anxiety and should be for in the early stages of therapy. Other side effe ally dose-related, have included isolated insta minor skin rashes, minor menstrual irregularities, consupation, increased and decreased libido. P cons.pation, increased and decreased libido. Pa—Following parenteral administration some patie become drowsy or unsteady. The injectable foccasionally produced mild, transitory fluctua blood pressure.

Precautions: Oral—In elderly tated patients, limit dosage to smallest effective to preclude development of ataxia or oversedal more than 10 mg per day initially, to be increase ally as needed and tolerated). Until the correct page dosage is established patients receiving the nance dosage is established, patients receiving the should be advised against possibly hazardous pro requiring complete mental alertness or physical nation. Caution patients about possible combine with alcohol. Caution should be exercised in ad ing Librium (chlordiazepoxide HCI) to addiction individuals. Careful consideration should be give pharmacology of any agents to be employed cantly—particularly the MAO inhibitors and philipped candidates. tantly-particularly the MAO inhibitors and phagines. Observe usual precautions in impaired hepatic function. Periodic blood counts and livition tests may be advisable in protracted to Parenteral – Indicated primarily in acute states, receiving this form of therapy should be kept uservation, preferably in bed, for up to three hours latory patients should not be permitted to opvehicle following injection. Reduce dosage when patients with impaired renal or hepatic functioning the patients with the patients injectable form should not be given to patients. injectable form should not be given to patients in or comatose states. Reduced dosage (usually 25 thould be used for elderly or debilitated paties for children.

August, 1963

The JOURNAL

of the Florida Medical Association

Process Conserve Conserve
Million Programme of Section
Conserve Conserve Conserve
Million Appropriate Conserve
Printing Appropriate Conserve
Printing Conserve Conserve
Section Conserve Conserve
Section Conserve



Helps the epileptic to realize his potential

DILANTIN (DIPHENYLHYDANTOIN SODIUM) PARKE-DAVIS



i most effective form of emotional approach remains the demonstranto the patient that the seizure phenomena can be adequately conord with anticonvulsant medication."

At esent, diphenylhydantoin sodium is generally regarded as the standard anticonvulsant medication because of its effectiveness in controln grand mal and psychomotor seizures. 2-10 It possesses a wide margin a lifety, and incidence of side effects is minimal. 4 With this agent, we dation is not a problem. 3 Moreover, its use is often accompanied by approvement in the patient's memory, intellectual performance, and mional stability. 11

ations: Grand mal epilepsy and certain other convulsive states.

nutions: Toxic effects are infrequent: allergic phenomena such as orthropathy, fever, skin eruptions, and acute generalized morbilling eruptions with or without fever. Rarely, dermatitis goes on to a iation with hepatitis, and further dosage is contraindicated. Eruptions a usually subside. Though mild and rarely an indication for stopping age, gingival hypertrophy, hirsutism, and excessive motor activity are sionally encountered, especially in children, adolescents, and young

adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia has been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

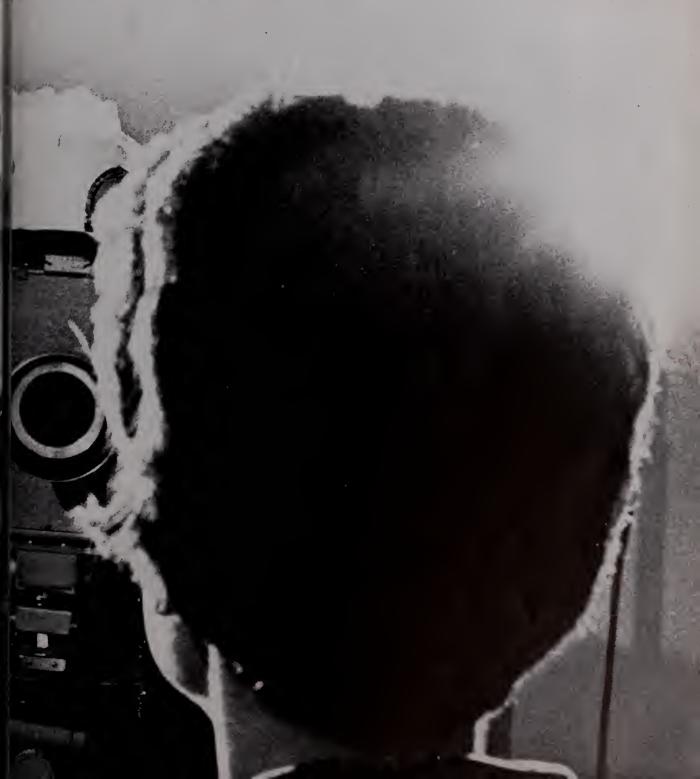
DILANTIN Sodium (diphenylhydantoin sodium) is available in several forms including Kapseals, $^{\odot}$ 0.03 Gm. and 0.1 Gm., bottles of 10Q and 1,000.

REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. 8:448, 1958. (2) Roseman, E.: Neurology 11:912, 1961. (3) Bray, P. F.: Pediatrics 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: M. Clin. North America 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, III., Charles C Thomas, 1954, p. 190. (7) Ibid.: Postgrad. Med. 20:584, 1956. (8) Marritt, H. H.: Brit. M. J. 1:666, 1958. (9) Carter, C. H.: Arch. Neurol & Psychiat. 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Selzures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Good-

Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

PARKE-DAVIS

RKE, DAVIS & COMPANY. Detroit 32. Michigan





NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

NTZ® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains Neo-Synephrine® HCI 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; Thenfadil® HCI 0.1% for topical antiallergic action; and Zephiran® CI 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U.S. Pat. Off.



Winthrop Laboratories New York 18, N.Y.

The JOURNAL of the Florida Medical Association

Volume 50, Number 2, August 1963

THIS ISSUE

Pseudo-Organic Illness in the Failing Flyer, Philip B. Phillips,

Articles

	Capt., MC, USN, and John A. Sours, Lt., MC, USNR	127
	Melanin Pigmentation of the Skin, John J. McAndrew, M.D.	131
	Florida's First Summer Camp for Diabetic Children,	
	Joseph C. Shipp, M.D.	133
THAD MOSELEY, M.D.	Meatus Size in 1,000 Circumcised Children From Two Weeks	
Editor	to Sixteen Years of Age, Henry G. Morton, M.D.	137
	Primary Septic Bursitis, Andre Marchildon, M.D., Roberta	
HALER RICHARDSON, M.D.	R. Slonim, M.D., Harvey E. Brown Jr., M.D. and David S. Howell, M.D.	139
Editor Emeritus	David S. Howell, M.D. The Importance of Skin Cover in the Injured Hand,	139
	Richard M. Fry, M.D.	142
Assistant Editors	Richard M. Pry, M.D.	142
CHARLES K. DONEGAN, M.D. FRANZ H. STEWART, M.D. JOHN M. PACKARD, M.D.	Editorials	
	Patto iuis	
THOMAS R. JARVIS	Psyche and Soma, Sullivan G. Bedell, M.D.	145
Managing Editor	Summer Camp for Diabetic Children,	
	Matthew E. Morrow, M.D.	145
Louise Rader Assistant	Smoking Habits in Lake County, J. Basil Hall, M.D.	146
Managing Editor	RD—Chronic Cough—Shortness of Breath,	
	Max Michael Jr., M.D.	147
EDITH B. HILL Editorial Consultant		
	Features	
	President's Page	144
	Association News	
	News	
	New Members	150
	Deaths	152
	Meetings	153
ublished monthly at Jacksonville.	Classified	154

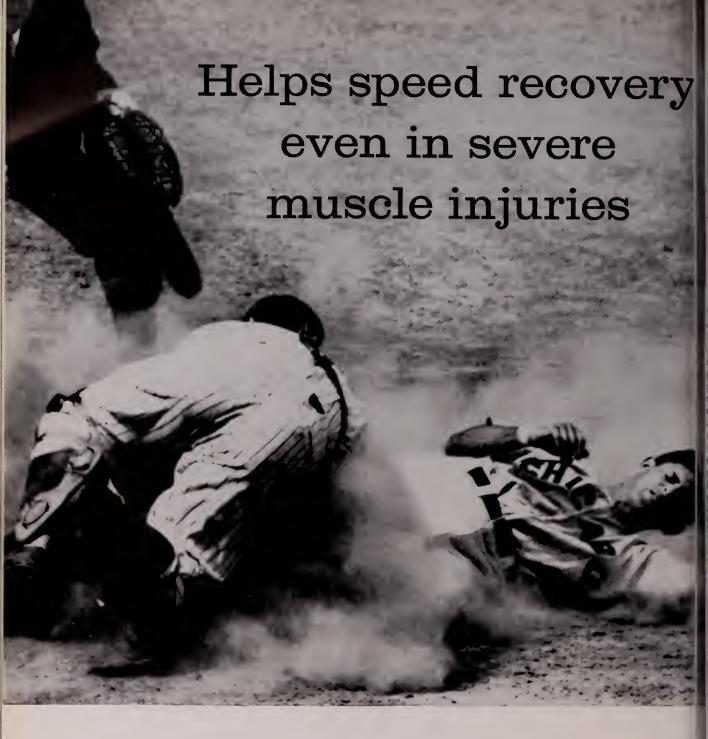
Books Received

Published monthly at Jacksonville. Florida. Price \$7.00 a year: single numbers, 70 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3. Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

This Journal is not responsible for the opinions and statements of its contributors. Owned and published by the Florida Medical Association.

Florida Medical Association Officers and Council Chairmen

156



Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. (Clinical Medicine, March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

For severe athletic strains or everyday sprains, you

can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D

The muscle relaxant with an independent pain-relieving action



Wallace Laboratories, Cranbury, New Jersey

AIDS TO:

Diagnosis Examination Treatment

New (11th) Edition! Beeson & McDermott - Cecil - Loeb TEXTBOOK OF MEDICINE

A new and distinguished team of Editors guides this well-known textbook in its New (11th) Edition. It provides precise and thorough descriptions of all those disease entities you are likely to encounter-over 800 in all. Each is discussed fully and completely: etiology, epidemiology; morbid anatomy; pathologic physiology; symptoms; diagnosis; prognosis; therapy. Contents range from a commentary on Patient-Physician Communication to Management of Bronchopulmonary Insufficiency. In this revision you'll find increased emphasis on pathologic physiology; a new section on Genetic Diseases; expansion of the material on Viral Diseases; reorganization and augmentation of sections on Bronchopulmonary Disease and Gastroenterology; a brilliant discussion of Nucleic Acids, Genes, Viruses, and Immunity; 67 new contributors. The text is available either as a single volume or a two-volume set.

AS a Single volume of a Inco-volume set. Edited by Paul B. Berson, M.D., Ensign Professor of Medicine, Yale University School of Medicine; and Waleh McDermott, M.D., Livingston Farrand, Professor of Public Health, Cornell University Medical College, With contributions by 173 authorities. With the assistance of S Associate Editors: Alexander G. Bearn, Philip K. Bondy, Carl V. Moore, Marvin H. Sleisenger, the late Harold G. Wolff. 1895 pages, 73% x 103, "x, with 238 illustrations. Single volume, \$19.50. Two-volume set, \$23.50.

New (2nd) Edition! Mayo Clinic - CLINICAL **EXAMINATIONS IN NEUROLOGY**

Here are the proved, successful techniques used at the Mayo Clinic in the neurologic examination. The book is written in concise, practical form-a series of working blueprints. The authors carefully guide the reader in developing his mastery of the clinically useful techniques in this important area of practice. You'll find effective techniques for taking the neurologic history, and reproductions of the various forms the Mayo Clinic staff developed for recording the history and the results of the clinical examination. They give you their order of procedure, their techniques of examination of the cranial nerves, motor function, reflexes, mental function, autonomic function, specific methods of examination for use in the sensory examination, etc. For this up-dated New (2nd) Edition the information in all chapters was brought up-to-the-minute. The problems of performing neurological examinations on infants are delineated in a full chapter, and a new chapter is devoted to roentgenographic techniques. You'll find a full measure of practical help in this up-to-date volume.

By Members of the Sections of Neurology and Section of Physiology, Mayo Clinic and Moyo Foundation for Medical Education and Research, Graduate School, University of Minnesotn, Rochester, Minnesoto. 396 pages, 61/2" x 91/4", illustrated, About \$9.00.

New (2nd) Edition—Just Ready!

Three new **EDITIONS** from SAUNDERS

New (2nd) Edition! Graham - THE CYTOLOGIC DIAGNOSIS OF CANCER

This valuable manual (formerly under auspices of the Vincent Memorial Laboratory) discusses the fundamentals, potentials and limitations of cytologic diagnosis of cancer-plus detailed, authoritative guidance on preparation and interpretation of cytologic smears. Material is based on study of tens of thousands of cases. Vaginal smears, smears of sputum or bronchial aspirations, urine sediment, gastric secretion and the sediment of serous fluid are all covered. Each chapter begins with an illustration and discussion of a histologic section of a particular tissue. This is followed by: (a) lower-power photomicrograph of a field of classical desquamated cells derived from that epithelium; (b) a higher-power photomicrograph of the same; (c) a colored drawing. In this New (2nd) Edition the cytological picture of dysplasia of the uterine cervix, the cytology of esophageal cancer, the cytology of needle aspirations of solid masses, and the cellular aberrations present in pernicious anemia are discussed in separate chapters. The material on histiocytes in vaginal secretion, and the chapter on adenocarcinoma of the uterine corpus are rewritten. Other valuable new chapters cover: the confirmation of unexpected positive reports; the reporting of smears; the identification of cells.

By RUTH M. GRAHAM, Sc.D. (Hon.), Roswell Park Memorial Institute, Buffalo. 387 pages, 63% x 934, with 992 illustrations on 311 figures. 32 color plates. About \$13.50. New (2nd) Edition—Just Reody!

To Order Mail Coupon Below!

W. B. SAUNDERS	COMPANY
West Washington Square	Philadelphia 5
Please send and bill me:	
☐ Beeson & McDermott— Cecil-Loeh Medicine 2 v	vol. set\$23.50
☐ Single Volume form	\$19.50
☐ Graham— Cytologic Diagnosis of Can	cerAbout \$13,50
☐ Mayo Clinic—Clinical Examinations in Neurology	yAbout \$9.00
Name	
Address	SJG 8-63



Here is a modern, clinicallyaccurate ECG of proven usefulness in thousands of practices — yet **light and compact enough** for even a slight nurse or technician to carry with ease.

Complete with all accessories, the Sanborn Model 300 Visette® electrocardiograph weighs only 18 pounds, is as compact as a ladies overnight case. Fully diagnostic, permanent 'cardiograms in all standard leads are recorded by heated stylus on inkless Permapaper®, for immediate interpretation. Simple paper loading, pushbutton "grounding", space for all accessories in the cover are a few of the Visette's convenience features. Your nearby Sanborn Branch Office or Service Agency will be happy to provide a demonstration or 15-day No-Obligation Trial of this modern, lightweight, moderately-priced 'cardiograph. Call your Sanborn man at your convenience.





SANBORN COMPANY
MEDICAL DIVISION Waltham 54. Mass.

MIAMI Branch Office 2907 N. W. 7th St., 305-635-6461
St. Petersburg Resident Representative
337-22nd Ave. N., 862-3229

JACKSONVILLE Resident Representative
2720 Park St., 384-3453

Abscess Acne Amebiasis, acute, intestinal Anthrax Bacillary dysentery Bacteremia Bartonellosis Bronchitis, acute Bronchopulmonary infection Brucellosis, acute (IN COMBINATION WITH OTHER ANTIMICROBIAL AGENTS) Chancroid Diphtheria (IN CONJUNCTION WITH ANTITOXIN AND ROUTINE ESTABLISHED THERAPY) Endocarditis, subacute, bacterial Genitourinary infection Gonorrhea Granuloma inquinale (OONOVANOSIS) Infections associated with pancreatic fibrosis Listeriosis Lymphogranuloma venereum Meningitis, purulent Mixed bacterial infection Osteomyelitis **Otitis** (EXTERNA OR MEDIA) **Pertussis Pharyngitis** Pneumonia (WITH OR WITHOUT BACTEREMIA) **Psittacosis** Pyelonephritis, acute and chronic Rocky Mountain spotted fever

Scarlet fever

proven effective in over



disease entities...

Septicemias (STAPHYLOCOCCAL AND PNEUMOCOCCAL) Sinusitie

Soft tissue infections

Tonsillitis

Tularemia

Typhus fever

Urethritis (NONGONOCOCCAL)

associated with tetracyclinesensitive microorganisms, the more important of which are:

STREPTOCOCCI

STAPHYLOCOCCI

PNEUMOCOCCI

CONOCOCCI

SHIGELLAE RICKETTSIAE

KLEBSIELLAE

and, in particular, with certain species of tetracycline-sensitive

microorganisms such

as the following:

HEMOPHILUS INFLUENZAE

STREPTOCOCCUS PYOGENES

OIPLOCOCCUS PNEUMONIAE

CORYNEBACTERIUM OIPHTHERIAE

ESCHERICHIA COLI

Surgical and dental preoperative and postoperative prophylaxis

Syphilis

(WHERE THE PATIENT IS PENICILLIN-SENSITIVE)

Typhoid fever

(WHEN CHLORAMPHENICOL IS CONTRAINGICATED) Agammaglobulinemia or hypogammaglobulinemia and recurring infections (WITH GAMMA GLOBULIN THERAPY)

ACHROMYCIN® V

TETRACYCLINE HCI WITH ACID

SIDE EFFECTS (infrequent and usually mild): glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. CONTRAINDICATIONS: None, but the following precautions should be observed: high-calcium-content foods or drugs should not be taken for at least one-half hour after each dose; avoid excessive accumulation of antibiotics by reducing dosage in patients with impaired renal function; consider possibility of discoloration of teeth during tooth development (late pregnancy, infancy or early childhood).

CAPSULES-250 mg. and 100 mg.; SYRUP; PEDIATRIC DROPS.

ederle

LEDERLE LABORATORIES . A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



For dramatic restoration WINSTROL brand of STANOZOLOL

Oral anabolic therapy with this new physiotonic helps restore the patient's: positive protein metabolism; confidence, alertness and sense of well-being.

WINSTROL (stanozolol/Winthrop), a heterocyclic steroid, combines highest potency* with outstanding tolerance, stimulates appetite and promotes weight gain...restores a positive metabolic balance. It counteracts the catabolic effects of concomitant corticosteroid or ACTH therapy. WINSTROL (stanozolol/Winthrop) rebuilds body tissue while it builds strength, confidence and a sense of well-being in conditions associated with excess protein breakdown, insufficient protein intake and inadequate nitrogen and mineral retention.

Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible, and patients receiving prolonged treatment should be examined and questioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time.

In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (preschool age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

Rx WINSTROL (stanozolol/Winthrop) whenever anabolic therapy is indicated



Winthrop Laboratories, New York 18, New York

Effective enema with only 6 cc. dosage?

Yes...with

SINGLE-USE ENEMA









1. Remove protective cap.

As easy as One-Two-Three



Indications:

- 1. Surgery: preoperative, postoperative cleansing.
- 2. Obstetrics: during pregnancy, pre- and postpartum.
- 3. Preparation for x-ray, proctoscopy, sigmoidoscopy where prior catharsis is not possible.
- 4. Simple constipation.
- 5. Atonic constipation.

Comfortable, safe

Soft, pliable rectal tube is safe and comfortable; helps prevent local tissue damage. Administered in seconds. Minimizes possibility of cross-infection. Messy clean-up procedures eliminated.

Effective

Hypertonic, blandly surfactant INDEX hydrates and softens the stool . . . initiates gentle peristalsis . . . produces effective evacuation, usually within a few minutes. Absence of bulk especially advantageous in parturient patients. Only minimal inflammation or local irritation noted in adults or children. Not contraindicated for patients on low-sodium regimens.

Economical

PATENT PENDING

Rapid technic saves valuable staff time. Substantially lower in cost than conventional disposable enemas. Demonstrably more economical than soap enemas because there are no hidden costs of preparation, washing, autoclaving or wrapping.

Administration: Patient should lie on left side, with left knee slightly bent and right leg drawn up. Alternate: knee-chest position. Insert tube into rectum and express contents.

Contraindications: As is the case with any enema, INDEX should not be used in the presence of acute surgical abdominal disease or local inflammation or infection.

Ingredients: Each 6-cc. INDEX Single-use Enema unit contains Sodium Lauryl Sulfoacetate, Sorbic Acid, Glycerin, Sodium Citrate, Sorbitol, Purified Water, U.S.P.

Johnson Johnson

NEW BRUNSWICK, N.J.

P-365 © J&J 1963

MADE IN U.S.A.



from confusion and apathy ...

... to Clarity and Interest

Cerebro-Nicin™

CAPSULES

A safe effective cerebral stimulant and vasodilator for your forgetful aging patient. On Cerebro-Nicin therapy, your patient shows improvement in social activity and relationships, and greater concern with personal appearance.

FORMULA:

PTZ (Pentamethylene

Tetrazole) 100 mg
Nicotinic Acid100 mg
Niacinamide 5 mg
Vitamin C
Thiamine HCI 25 mg
Riboflavin 2 mg
Pyridoxine 3 mg
1-Glutamic Acid 50 mg
INDICATIONS: Apathy, dizzy spells mild behavior disorders, mental con fusion, functional memory defects.

AVERAGE DOSE: One capsule three times daily.

AVAILABLE: Bottles of 100 and 500 capsules.

CAUTION: Most persons experience a flushing and tingling sensation after taking a higher potency niacincontaining compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause for discontinuance of the drug if the patient is forewarned to expect the reaction.

WARNING: Contraindicated in the presence of epilepsy.



Write for samples and literature...

THE BROWN PHARMACEUTICAL COMPANY
2500 West Sixth Street, Los Angeles 57, California



ADVANTAGES -

Chelated Iron PLUS 4 Chelated Minerals
• High Therapeutic Effectiveness
• Less
Irritation — even on empty stomach
• No Tooth Stain • Less Toxic • B-Vitamins
for Added Hemopoietic Activity • Pleasant Flavor • Economical

Cabalt (as Cabaltaus Beta Manganese (as Manganese Zinc (as Zinc Betaine Citr	ul) cantains: Citrate)
Vitamin B-2	1.5 mg 1.2 mg 6.0 mcg.
Niacinamide	10 mg.

The FIRST Hematinic to Contain BOTH CHELATED IRON and CHE-LATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

KELATRATE

CHELATED IRON-MINERALS
and VITAMINS

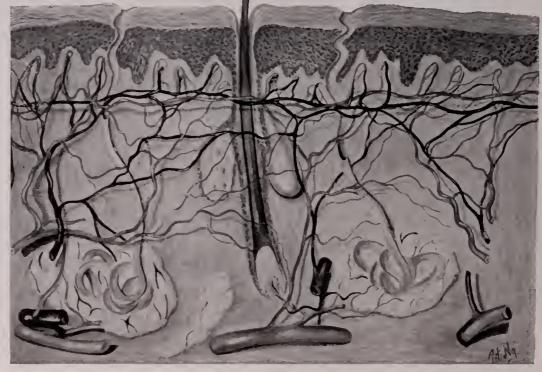
Comprehensive literature and samples on request.

S. J. TUTAG & CO.

DETROIT 34,

MICHIGAN

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B — bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of non-susceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅓ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN ANTIBIOTIC OINTMENT



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

there is nothing 'new' about Thorazine®



chlorpromazine

In the nine years since it became available to American physicians, Thorazine (chlor-promazine, SK&F) has been more widely used, more thoroughly investigated and more extensively documented than any other agent of its type.

Its actions, effects—and side effects—are well known throughout the medical profession. Its efficacy has been clearly demonstrated. And when properly used, its advantages far outweigh any possible disadvantages.

This is why there is nothing "new" about Thorazine (chlorpromazine, SK&F). This is why it remains the first choice in many conditions—and the standard against which other agents are inevitably compared.

This is why it is one of the fundamental drugs in medicine.

SMITH KLINE & FRENCH LABORATORIES, PHILADELPHIA



A special margarine for the atherosclerosis diet

The latest report* in the JAMA on atherosclerosis diets states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

Since this report recognizes table spreads as an important source of dietary fat, we believe that it is in your professional interest to know about the fatty-acid composition of Mrs. Filbert's Corn Oil Margarine.

Mrs. Filbert's Corn Oil Margarine is a special margarine** made from 100% corn oil, over 50% of which retains its liquid characteristics.

Because of its high linoleic content, its ratio of polyunsaturates to saturates is about 1.7 to 1... and equals the highest level available today in *any* corn oil margarine.

Of the total fatty acid content, 28% is cis-cis linoleic acid.

Moreover, when you recommend Mrs. Filbert's Corn Oil Margarine, your patient is assured of receiving unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).

**AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



Made from 100% corn oil with liquid corn oil as its major ingredient For additional information—including detailed listings of component characteristics—please write to us.

J. H. FILBERT, Inc.

BALTIMORE 29, MARYLAND



- even when OSTEOPOROSIS is present

PABALATE-SF, which has been found "superior to aspirin in the treatment of chronic rheumatic disorders," possesses distinctive **Safety Factors** for elderly arthritics, even when osteoporosis is present: (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) it does not produce the serious reactions often noted during therapy with steroids or pyrazolone derivatives.

In each persian-rose enteric-coated tablet: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal

impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

Pabalate SF Robins (the new, convenient way to prescribe Pabalate-Sodium Free)

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

- 1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.
- 2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.
- 3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness ("numbs the pain...not the patient").

- 4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.
- 5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

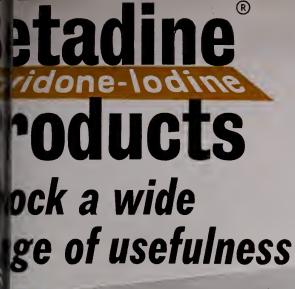
Soma Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg

Soma®Compound+Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg. codeine phosphate 16 mg. (Warning — may be habit forming.)

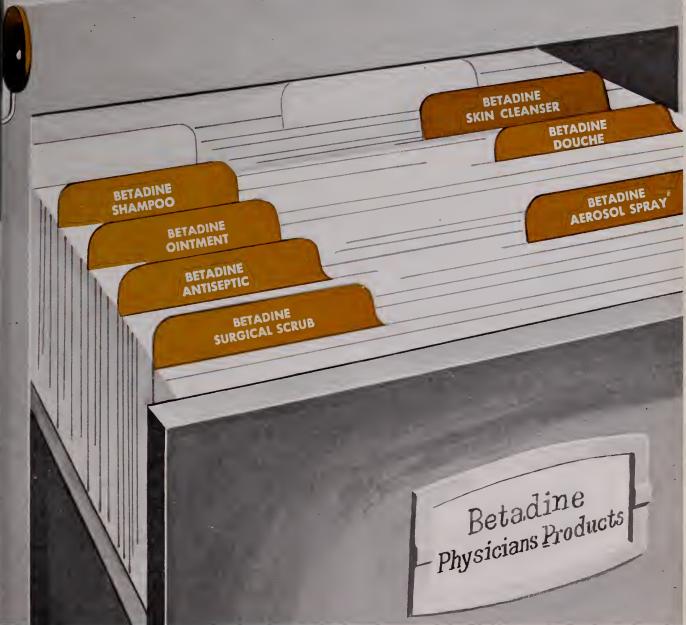
**WALLACE LABORATORIES / Cranbury, N. J.



Betadine Products, in all seven dosage forms contain povidone-iodine, a complex of polyvinyl pyrrolidone and iodine, providing all the germi cidal properties of elemental iodine . . . yet Beta dine (povidone-iodine) is nonirritating, nonsensitizing, and nontoxic to skin or mucosa.

Betadine Products are effective in preventing and treating a variety of infections frequently encountered in the practice of otolaryngology, orthopedics and orthopedic surgery, obstetrics and gynecology, oral surgery, pediatrics, surgery and dermatology.

The clinical results reported under various conditions of use make Betadine (povidone-iodine) preparations valuable adjuncts both in the hospital and in private practice. Literature available upon request.





PRODUCTS CO., INC.
PETERSBURG, VIRGINIA



We like visitors. We like to show them our modern equipment and latest research facilities, our exacting manufacturing techniques and unexcelled quality standards. Up to a point, that is. A white line provides the barrier that discourages further exploration. It means look but don't cross. It is a safeguard against inadvertent mishandling or misplacing of products—another precaution in an endless list of rules contributing immeasurably to the quality of the finished product.

Lilly

The JOURNAL

of the Florida Medical Association

Pseudo-Organic Illness in the Failing Flyer

PHILIP B. PHILLIPS, CAPT., MC, USN AND JOHN A. SOURS, LT., MC, USNR PENSACOLA

The kinship between the psychiatrist and the internist is and should be close. The psychiatrist has criticized his colleagues in medicine for not taking a comprehensive history of the social and emotional life of the patient. The internist has replied that, too often, the psychiatrist has failed to keep up in the clinical and laboratory phases of medicine and has retreated to the psychiatrogenic delusion that all illness is mental. This internecine warfare between brother physicians ultimately benefits our patients, if it makes us strive to be better informed physicians and more attentive to the whole man.

At the headquarters of the Naval Air Training Command in Pensacola, some 3,000 young men embark annually on careers in naval aviation. Statistics show that one of every three fails to complete the training program and be designated as a qualified naval aviator (table 1). Yet these young men have met relatively high academic standards and passed various aptitude tests and comprehensive physical examinations prior to entry into flight training. Why do they fail to graduate? We know that some do not measure up academically, some elect to withdraw voluntarily, and some seemingly cannot develop the required psychomotor coordination for safe handling of aircraft; but the incidence of "illness" in these supposedly healthy young men has been impressive to us.1 How can symptoms develop so readily in 20 to 22 year old young men? What type of symptoms do they show? Is there a common denominator in their illnesses?

Because of our experience with physicians failing to elicit psychological material in patients' histories, we have sought, in most of our case material, to find organic pathology whenever possible. Adequate utilization of x-ray, electroencephalogram, electrocardiogram and the clinical laboratory has too often been of no real help in establishing diagnoses, other than the help that is given by a normal finding. If these "illnesses" are not strictly organic, then, in our dichotomous reasoning, they must be "functional," whatever this really means. What are the stresses of aviation training, and why is illness selected as the way out?

Actually, there are several potential sources of tension for a young man entering military aviation. He is away from home. He is in an all-male environment. He is strictly accountable for his personal behavior. His life is regulated with definite things to be done at specific times. He is in constant competition with his fellows and graded daily in his progress; but over and above all these, he is learning to control an inanimate machine which can kill him. The recognition of this potential seems to be the most stressful experience of flight training.2

Admittedly, we have had greater experience professionally with the failing aviator than with the man who meets no insurmountable conflicts in his flight training experience. We would not want to give the impression that all students have difficulties. Some young men take to flying as the proverbial duck takes to water, but in a surprisingly high percentage symptoms develop due primarily to imbalances of the autonomic nervous system.3 We have classified the stresses under the headings which we call "the 4 F's which foul

From the Department of Psychiatry and Neurclogy, U. S. Naval School of Aviation Medicine, U. S. Naval Aviation Medical Center, Pensacola.

Presented before the American College of Physicians, Southeastern Regional Meeting, Point Clear, Ala., Oct. 20, 1962.

Opinions and conclusions expressed in this paper are those of the authors and do not necessarily reflect the views or endorsements of the U. S. Navy Department.

Table 1. - Student Aviator Attrition

In the year 1957 3,800 students began 18 month program During that year 2,951 completed the flight course That year 1,304 students lost by attrition Per cent 37.0 flight failure 6.0 academic failure 35.0 voluntarily withdrew (not aviation material) 4.0 unsuitable officer material 14.0 not physically qualified (Medical Department) 2.5 death Average attrition 30 per cent

Table 2. — Diagnostic Groups

Gr	roups	Patien
1.	Manifest fear of flying syndrome	146
	Airsickness	89
3.	Disturbances of consciousness	49
4.	Anxiety reactions and hyperventilation	
	syndromes	28
5.	Personality disorders	28
6.	Musculoskeletal reactions	22
7.	Visual reactions	20
8.	Gastrointestinal reactions	13
9.	Depressive reactions	12
	Cardiovascular reactions (labile hypertension)	11
11.	EEG abnormalities (asymptomatic clinical	
	histories)	9
12.	Migraine headaches and equivalents	7
13.	Hysterical reactions	6
14.	Speech disturbances	3
	Hearing disturbances	3
16.	Schizophrenic reactions	3
	Total number of patients	449

up the flyer." These are fear, frustration, fatigue and families.4

Diagnostic Study

In a four year study of 449 aviation patients with possible psychiatric disorders, 16 diagnostic groups could be established on the basis of predominant symptomatology. We have isolated several diagnostic groups for presentation to illustrate the pseudo-organic qualities of many of these reactions (table 2).

It was found that 32 per cent of these young men displayed signs and symptoms of manifest fear of flying syndrome. Nineteen per cent were disabled by airsickness, 10 per cent by disturbances of consciousness, 6 per cent by acute anxiety reactions with hyperventilation symptoms, and $4\frac{1}{2}$ per cent by visual disturbances which proved to be psychogenic.

Table 3 indicates the wide spectrum of symptomatology associated with the manifest fear of flying syndromes. Basically, these men were depressed and manifestly frightened. Sadness, insomnia, asthenia, all-pervasive anxiety and psychophysiological reactions characterized the group.

Eighty-seven per cent evidenced frank signs of overactivity of the autonomic nervous system. Significantly, these men generally admitted that, although they were fearful of flying and displayed breakdown of homeostasis, they felt compelled to remain in the program. The diagnostic identification of this group was not difficult. They had reacted psychophysiologically to the stresses of flight training, but their flight surgeons were quick to recognize the absence of pathophysiologic and structural lesions, and readily referred these men to our department.

On the other hand, other reactions at times suggested a truly organic etiology. These were classified as symptomatic of a latent fear of flying syndrome, and while these men were not depressed or obviously anxious, their symptoms included hyperventilation symptoms, disturbances of consciousness, psychogenic visual disturbances, and airsickness. In these reactions, fear was either repressed or suppressed. It was often occult to the flight surgeon and medical consultants, and, at times, even to psychiatrists.

Several of these reactions demonstrate well the pseudo-organic illnesses with which aviators present. For instance, 41 syncopal reactions occurred in this group (table 4). Twenty-six of them had experienced a syncopal episode while pulling G's. Careful neurologic and cardiologic evaluations were negative. The same aviators tested in the human centrifuge did not show low G-tolerance. These men had cardiovascular responses, compensatory to angular and accelerative forces, which were altered by affective and psychophysiological states manifested in flying. Silverman, Cohen and Zuidema⁵ elucidated the psychophysiology of low G-tolerance.

Acute anxiety reactions and hyperventilation symptoms manifested by states of disequilibrium, disorientation, and peculiar somatic sensations while in flight suggest an organic verisimilitude in aviation medicine (table 5). The following brief report of a case is pertinent:

Report of Case

A 30 year old white male Marine captain aviator had experienced five episodes of palpitation, profuse sweating, lightheadedness, and narrowing of visual fields while in actual control of F3D's and F8U's at high altitudes. Two of these episodes were of major proportions, lasting approximately 15 minutes. While flying at 16,000 feet, he experienced a "hot flash in the stomach," violent enough to cause him to bend forward. Almost immediately, peripheral vision dimmed. Palpitation, diaphoresis and lightheadedness were noted. He found it difficult to read the instrument panel and had to shake his head and move his body so as to "clear my blurred vision." He noted that oxygen did not result in any diminution of symp-

toms. The episode cleared after 15 minutes and descent to lower altitude. Four more such episodes occurred before the patient was referred to our department. Evaluations by the Departments of ENT, Ophthalmology, Internal Medicine and Cardiology were all normal. Neurological examination revealed only a slight hand tremor of the anxiety type. Although it was thought by the Psychiatry Department that the symptoms were manifestations of acute anxiety, the diagnosis and etiology were uncertain. Decision was made that the patient should have a test ride in the AD research aircraft. In preparing for the flight, he became markedly anxious and refused to fly. A more comprehensive psychiatric evaluation revealed that his anxiety was probably related to his attempt to suppress his dependency upon his wife and to accept the responsibilities of flying, which, he thought, challenged his relationship with his wife.

Psychophysiological visual disturbances (table 6) in aviation often suggest either refractive defects or structural lesions of the central nervous system. This is especially true of variable visual acuity related to ciliary muscle spasm. Episodes of blurred vision and partial field obliterations resulting from retinal arteriolar spasm are also seen.

Discussion

From our experience, conclusions can be drawn. In military aviation, young men of varying capacities, experiences and aggressivity are faced with one common goal: psychomotor mastery of themselves and supersonic aircraft which can only result by fusion of the pilot's body image and self image with his aircraft. This union of animate and inanimate aggression, as well as potential inner and outer directed destruction, is capable of disturbing the homeostasis of these young men, many of whom are intolerant of their own aggressive instincts. The resultant fear, rage and guilt lead to physical symptoms which, in our illness-oriented culture, are socially permissible ways of expressing conflict with the environment. Such disguised psychic mischief is tolerated by the military authorities, peers and families, especially if the symptoms involve a sense modality, an alteration in consciousness, or a disturbance in function essential to good flight performance. In other words, the appearance of the pseudo-organic disturbance is, in large part, determined by the norms of society. The failing pilot is thereby protected from being aggressive, both in the air and on the ground. His fears of retaliation are likewise assuaged.

Just as there are pseudodisorders of medicine—such as pseudohypoparathyroidism and pseudotumor—there are pseudo-organic illnesses in psychiatry. The failing aviator is pseudo-organically ill. He is reacting physiologically to intolerable feelings, and to this extent, he is organically

Table 3. — Manifest Fear of Flying Syndrome Symptomatology

	Symptoms	Patients
1.	Depression	
	Primary (sadness)	81
	Secondary (guilt, insomnia, etc.)	75
2.	Anxiety	
	Primary (apprehension, dread, etc.)	37
	Autonomic nervous system overactivity	128
3.	Psychosomatic disturbances	
	Tension headache	65
	Dizziness	24
	Nausea and vomiting	20
	Epigastric distress	20
	Back pain	18
	Diarrhea	6
	Hyperventilation (dyspnea, dizziness	
	and paresthesias)	8
	Airsickness	7 7 5 4
	Constipation	7
	Blackout	5
	Disorientation	
	Labile hypertension	4 2 2 2 2 2
	Diplopia	2
	Stammering	2
	Precordial symptoms	2
	Neurodermatitis	
	Spastic colitis	1
	Aphthous stomatitis	1
4.	Dreams	
_	Flying disasters	11
5.	¥	
	Globus hystericus	4
	Anesthesia	1
	Visual impairment	5
	Monoparesis	1 1
	Hearing impairment Pain	3
	Pain Amnesia	
	Annesia	1

Table 4. - Disturbances of Consciousness

Reactions	Related to Flying		Unrelated to Flying	
Syncopal	41	26	15	
Convulsive	8	0	8	

Table 5. — Anxiety Reactions and Hyperventilation Syndrome in Eleven Patients

Latent Fear of Flying Symptoms

Loss of equilibrium
Hyperventilation syndrome
Blackout
Acute anxiety attack
Disorientation
Epigastric "hot flush," etc.
Peculiar somatic sensations
Specific fear: type aircraft, altitude, etc.

Table 6. — Disturbances of Vision (Normal Ophthalmologic Evaluation)

Symptoms

Inadequate distance vision
Faulty depth perception
Right superior temporal quadrantal field defect
Bitemporal hemianopsia
Loss of vision for one-half of instrument or watch dial
Bilateral blurred vision
Variable visual acuity
Intermittent constriction of visual fields
Poor vision, left eye

ill in relation to his environment and is unable to respond appropriately to it. Our culture, furthermore, blesses his psychic deception and reenforces his rationalization that he is organically sick.

We in naval aviation medicine approach this problem in one of several different ways. We may say to the symptom-laden student aviator who seems mature and intelligent that, for his own later mental health, he must voluntarily drop from the flight program, rather than our dropping him for pseudomedical reasons. We believe this approach is often therapeutic. Other students we give a medical drop as the most expeditious way to remove them from demands they cannot meet. Others, when possible, are salvaged through short term psychotherapy. In general, we think that men in whom pseudo-organic symptoms develop in the relatively mild stresses of beginning flight training should be removed from the program as promptly as possible, since nothing about naval aviation gets less demanding as one moves into the more advanced planes.

We do not hold that the flight training is the only cause of the student's symptoms. Rather, it is often the straw that breaks the camel's back. Removal of this added burden, however, may be the difference between health and illness.

Are we helping the man basically to take him out of the stressful situation? We are implying, as physicians, that his symptoms will remit when he is removed from the added stress; but, as military officers, we are also implying that he is afraid of the aircraft. When we believe the ego strength of the man is sufficient, we are frank with him and try to explain that fear is an honest emotion and often productive of symptoms, particularly when one has accurately appraised one's own capabilities. Perhaps it would be better to point out to him that aggression, and aggressive instruments and behavior at a certain threshold, upset his over-all physiological economy in a manner that is socially acceptable to most people, that is, productive of symptoms of illness, and that he thus is enabled to retreat into a quagmire of passivity.

When we have forced a young student to admit his fears, face the line officer, and voluntarily quit his flight training, we believe we have accomplished more for the man than when, in protective fashion, we medically drop him. The thought then arises: would not this same approach be more effective with private patients in their own emotional growth than the overprotective, sympathetic dispensing of tranquilizers? A man's boss, or even his wife, is hardly as potentially destructive as a jet aircraft; yet, if we bless his muscle-contraction headache or his recurrent epigastric distress with the rubric "functional," and prescribe pills, we, in a sense, imply his adversary is as lethal as a rocket-firing jet diving "on target," and encourage him to drop any further assertive, interpersonal attitudes.

Is this really what we want from our patients? Only a callous medical officer would force a frightened, ill student aviator to fly a plane he sorely feared; but, on the other hand, only a passive physician would permit his private patient to renounce his potential assertiveness and wallow in dependency and passivity. The doctor-patient relationship must not be ignored with patients showing recurrent psychophysiological "illness."

- 1957.
 Phillips, P. B., and Bair, J. T.: Preventive Medicine in Naval Aviation Training; The Cooperative Efforts of Psychology and Psychiatry, A.M.A. Arch Indust. Health 17:53-57 (Jan.) 1958.
 Silverman, A. J.; Cohen, S. I., and Zuidema, G. D.: Psychosomatic Factors in Black-out, J. Nerv. & Ment. Dis. 125:64-68 (Jan.-Mar.) 1957.
- 1515 West Moreno at K (Dr. Phillips).

Melanin Pigmentation of the Skin

John J. McAndrew, M.D. Orlando

Melanin, a colored protein complex, is largely responsible for the tinctorial differences that exist in the skin, hair and eyes of man. Microquantitative studies of human epidermis have established that the variation in the hue of the skin in the Caucasian, Asiatic, Indian and Negro races is not related to the number or distribution of pigment-producing cells, which appear to be the same for all races, but to the content of melanin in the pigment-producing cells, the melanocytes.¹

The epidermis is usually about as thick as a sheet of writing paper. Microscopically the epidermis averages about 10 cells in depth. The melanin pigment-producing cells are individually situated in the lowermost epidermal cell layer. About every twentieth cell in the bottom or basal cell layer of the epidermis is a melanocyte. A horizontal pigmented network is formed by long cytoplasmic extensions of melanocytes interconnecting and weaving in among the other epidermal cells. Within these melanocytes the amino acid tyrosine is enzymatically (tyrosinase) converted into melanin (Greek melas, melanos, black). The melanocyte actually is a one-celled gland which secretes melanin. A common example of failure of the melanocyte to secrete melanin is the graying of the hair.

Role of Melanin

The principal known role played by melanin in the skin is to act as a light trap, an epidermal screen of pigment protection placed between ultraviolet light and the highly vascular dermis. Without melanin, mankind would have to dwell in sunless areas or face painful death and possible extinction from squamous cell carcinoma arising in the exposed areas.² Some indication of the severe difficulties man would experience from repeated exposure to ultraviolet light without melanin protection are seen today. The most susceptible subject for sunburn and cutaneous malignant disease is the person with a fair complexion who has but little pigment in his skin and little capacity to form more.³

Blue-eyed and red-haired descendants of blueeyed parents having a fair, sometimes freckling complexion compose the group most susceptible to malignant lesions of the skin. Malkinson and Rothman⁴ documented their occurrence on the areas exposed to sunlight, 91.1 per cent occurring on the face, ears, neck and hands.

The ability to tan is a welcome genetic endowment for it takes more than the Florida sunshine to give some persons a tan. Sun tanning is a complicated biochemical phenomenon. Besides the true tanning effect, there are also immediate and delayed tanning effects. The true tanning effect is brought about by the formation of new melanin in the melanocytes. This is in response to stimulation by the same wavelengths (2900A-3100A) of ultraviolet light that produce sunburn in persons who tan poorly. True tanning effect begins two days after exposure, peaks in degree in two or three weeks and declines slowly over a period of months.⁵

Immediate tanning effect is not true tanning in that no new melanin is formed, but colorless, reduced melanin, previously formed, is photo-oxidized and darkened. This immediate tanning may be sudden in onset, the person becoming noticeably darker in just a few minutes after exposure to sunlight. This is the mechanism involved in the Meirowsky phenomenon.

The delayed tanning effect is also not a true tanning effect. Melanin is not newly formed but merely moving upward in the epidermis from the basal cell layer. Probably this migration of melanin granules occurs as a result of dispersion within the dendritic extensions of the melanocytes. This delayed tanning effect occurs several days after exposure to sun. It occurs also in the postinflammatory hyperpigmentation seen in association with inflammation of or injury to the skin.

Almost every skin disorder is accompanied by some change in the color of the skin. Clinically, changes vary from the very subtle and evanescent to the startlingly evident. Changes in the pigmentation of the skin require careful clinical interpretation, for etiological associations range from the local to the systemic and from the non-portentous to the lethal. Even normality of melanin pigmentation may be misleading.⁶ The normal color of the skin of a person who tans well may be no different in appearance or measure-

ment from that of one with Addison's disease who tans poorly. One may have to depend on the history; friends or relatives may have noted a darkening of the skin, or, in areas of marked seasonal changes, a summer tan may not fade as expected. Hyperpigmentation of the mucous membrane of the gums, tongue and buccal mucosa is a normal finding in the Asiatic, American Indian and Negroid races.

Decreased pigmentation is ordinarily clinically visible in visible light. Black (Wood's) light is better for determining this change. Wood's light (3650A) makes melanin pigmentation look darker and will thereby create greater contrast than visible light. Wood's light is one of the few aids to the clinician in determining change in pigmentation of the skin. Reflectance spectrophotometry studies repeatedly made assist only in estimating a change in the intensity of pigmentation. In extensive pigmentary change, without palpable lesions of the skin, histopathologic study is usually to little avail except in a few special instances as in hemochromatosis.

Melanin occurs ordinarily as brown or tan particles. When situated below the epidermis, the brown melanin in skin lesions may look bluish or grayish to the examiner's eye like it does in the classic blue nevus and Mongolian spots. It appears so because the epidermis is a turbid medium and scatters visible light, reflecting the shorter (blue) and transmitting the longer (red) wavelengths. Atmospheric air is also a turbid medium and looking through it is why the sky looks blue. This is the Tyndall phenomenon.

In the lower animal forms melanin is the main basis of protective coloration. The squid ejects a melanin "smoke screen" in the water to divert its enemy. Seasonal changes in coloration of fur in the rabbit and fox provide protection through camouflage. The color changes are related to the total period of light in a day and are mediated through an afferent visual pathway. The striking effect of coloration on survival is illustrated by the observation of certain species of moths in England by Kettlewell;7 with development of industrialization in the urban areas, the moths are required to achieve coloration for survival. Unless the requisite mutations have taken place in time, the moths are driven out.

Summary

Melanin, the principal skin pigment, is of importance, perhaps critically so, to man's survival in sunshiny areas on this planet. The chief function of melanin pigment in man appears to be the prevention of carcinoma arising in unprotected skin from repeated exposure to ultraviolet light (3000A).

Melanin pigmentation of the skin is the main factor which accounts for the differences in color of the various races of man.

Melanin pigment is usually light brown in actual color. It may appear blue when situated deep in the skin because of the refractive and reflective properties of the tissues through which this pigment is seen.

There is no blue pigment in the sky, nor in the eyes of blue.

The blue we see is determined by what we are seeing through.

It is speculated that the therapeutic use systemically of a metabolically guided missile of some radioactive amino acid melanin precursor may someday cure the dreaded malignant melanoma. Tyrosine itself cannot be used safely because of its, other than melanin, metabolic products (thyroxin-epinephrine). It is further conjectured that if malignant melanoma is cured in this fashion, the cure might involve total melanocyte destruction with resultant acquired albinism of the patient.

Melanin pigment also plays an important role in the protective coloration of the animal world.

References

- Szabo, G.: Quantitative Histological Investigation on Melanocyte System of Human Epidermis, in Gordon, M., editor: Pigment Cell Biology, New York, Academic Press, 1959, pp. 99-125.
- Blum, Harold Francis: Carcinogenesis by Ultra Violet Light; An Essay in Quantitative Biology, Princeton, N. J., Prince-ton University Press, 1959. Mackie, B. S., and McGovern, V. J.: The Mechanism of Solar Carcinogenesis, A.M.A. Arch, Dermat. 78:218-244
- Aug.) 1958.
 Malkinson, F. D., and Rothman, S.: Skin Cancer: Its Causes, Prevention and Treatment, Cancer 7:190-195 (Nov.) 1957.
- 1957.
 Lorinez, A. L.: Physiological and Pathological Changes in Skin from Sunburn and Suntan, J. A. M. A. 173:1227-1231 (July 16) 1960.
 Fitzpatrick, T. B., and others: Melanin Pigmentation, New England J. Med. 265:374-398 (Aug. 17) 1961.
 Kettlewell, H. B. D.: New Aspects of Genetic Control of Industrial Melanism in Lepidoptera, Nature 183:918-921 (Apr. 4) 1959.
- 61 West Columbia Street, Suite F.

Florida's First Summer Camp for Diabetic Children

Joseph C. Shipp, M.D. Gainesville

The value of summer camps for children with diabetes mellitus is clearly established.^{1,2} They provide supervised and complete recreational activities, an opportunity to live with others with diabetes mellitus, a better understanding of diabetes, freedom for parents, a unique educational experience for the medical staff and an economical means of "learning with fun."

Historically, the first camp for diabetic children was established by Dr. Leonard F. C. Wendt of Detroit soon after the introduction of insulin. In 1929, Dr. Henry John of Cleveland started Camp Ho Mita Koda, which was the first to operate continuously to the present time. Slowly other camps were opened, but in 1951 there were only 15 camps in the United States and Canada.³ During the period from 1951 to 1962 the number of camps has more than doubled.

Camp Immokalee, the Florida Camp, is the thirty-third in the United States and the third camp in the Southeast, the others being Camp Seale Harris in Alabama and Tennessee Camp for Diabetic Children. For several years a large number of Florida children with diabetes have attended camps in other states. The problem of transportation has emphasized the desirability of having a well run camp in Florida.

Founding of Immokalee

The Florida Camp was sponsored by the Florida Diabetes Association. A committee of five appointed by the president, Dr. Theodore F. Hahn Jr. of DeLand, was responsible for all organizational activities. The committee members included Dr. Matthew E. Morrow Jr. of Jacksonville as treasurer, Dr. Richard H. Sinden of St. Petersburg, who selected the campers, Dr. Seymour L. Alterman of Miami Beach, who helped in the selection of camp site and planning, and Dr. Joseph C. Shipp of Gainesville, who selected the medical staff and served as medical director during the two week camp period. Mrs. Jack Van Der Beek of Bradenton, an active member of the Diabetic Lay Society, was, to a large extent, the key member of the committee in her role as secretary; she has worked on the camp project for five years and assisted in all phases of the planning and operation of Camp Immokalee. For her work she has been chosen as the outstanding diabetic lay worker for 1963 by the American Diabetes Association.

It was decided to have a two week camping period and to limit the campers to 50 between the ages of 10 and 14 for the first year, an age group thought to benefit maximally from this type of experience. The camp was financed largely by the campers (\$75 for two weeks) although no camper was denied the privilege of attending because of funds. Efforts were successful in helping campers to find support from civic, church or other local groups. Two were financed by the Florida Diabetes Association Camp Fund. A major financial contribution was made by the Beta Sigma Phi Women's Sorority.

Two factors were responsible for smooth, effective operation in the first season:

- 1. The opportunity to use the Jacksonville Y.M.C.A. Camp Immokalee with all phases of camp activities carried out by the expert camp staff.
- 2. Cooperation of the University of Florida Health Center in providing the medical staff.

Camp Facilities and Activities

Camp Immokalee, which in the Indian means "permanent campsite," has been in operation since 1903. It consists of 160 acres of rolling woodland on Lake Brooklyn, a cool clear lake with sandy beach and abundant fish in North Central Florida. Spacious cabins have facilities for 144 campers. A large well equipped kitchen and dining hall, recreation lodge, modern sanitary facilities, a superior infirmary, administration building, crafts shop, trading post, nature center, chapel, land sports area, archery and rifle ranges, stable of 10 horses with miles of trails, and complete waterfront for swimming, rowing, canoeing, sailing, and skiing provided ideal camping facilities. The infirmary, built in 1959, with a bed capacity for 20 also served for staff quarters and laboratory. A staff lounge was conveniently located on the periphery of the camp area. It can be seen that the

Table 1. — Campers by Age Groups Showing Incidence of Heredity, Duration of Diabetes and Insulin Dosage

Age Groups	Number of Compers (39)	Heredity	of		(units/day) Chonge Leaving %
9-10.9	10 (8*)	3	5.4	43	35 -19
				(22-72)	
11-11.9	7	_			29 -17
			(0.5-11)	(14-52)	(10- 42)
12-12.9	8	5	3.0	38	34 -11
			(0.5-7)	(22-76)	(10-102)
12-13.9	7	4	4.7	61	58 - 5
		((0.5-11.5)	(8-178)	(16-170)
14-14.9	7	4	5.4	47	49 +4
			(0.3-14)	(28-104)	(28-100)

^{*} Insulin dosage for 8 (one had omitted insulin before camp and another left camp early).

diversity of activity made it possible for each of the 41 campers to participate in any activity for which he was prepared.

Camp Staff

The Y.M.C.A. staff numbered 20. Included were cabin counselors, counselors for each activity and a kitchen staff, all under the direction of Mr. Vern O. Harper. The voluntary medical staff of 20 from the University of Florida included three physicians, two senior medical students, one graduate and five student nurses, two dietitians, a laboratory technician and three assistants, two who were responsible for records and one person who worked jointly with the Y.M.C.A. program staff. Each cabin included a camp counselor and either a medical or nursing student. All recreational activities were left entirely to the camp staff although a member of the medical staff was present with each group at all times to observe for signs of hypoglycemia.

Daily Program

The daily program followed was similar to that described by Smelo and Eichold.² The only major change from the usual camp schedule was placing vigorous activities such as swimming and horse-back riding soon after a meal, or refreshments, to minimize the problem of hypoglycemia. Morning refreshments and blood glucose determinations were at 10 a.m. at the end of period 1; this was only one and one-half hours after the completion of breakfast, and hence the blood glucose values ran high. The morning refreshments and blood sugars could be scheduled after period 2 at 10:50 a.m. without danger of hypoglycemia, with the two and one-half hour post-breakfast blood sugar of more value in evaluating response to treatment.

It was found that the period before lunch was optimal for formal instruction since campers remained awake, and, if hypoglycemia developed, it was immediately detected and treated.

Observations on Campers

1. General Comments

Each of the 41 campers had a physical examination by his family physician and was immunized against poliomyelitis, tetanus, typhoid and paratyphoid. A physical examination was made on arrival. No retinal hemorrhages, exudates or microaneurysms were noted. One camper had bronchial asthma which was easily controlled; another had moderate hepatosplenomegaly and lymphadenopathy. No camper was excessively overweight or underweight.

2. Diet

Parents were requested to submit the exact diet of each camper in advance. Information provided was incomplete, and campers were started on a 2,200 calorie basic diet. This was subsequently adjusted with the camper sharing in the decisions. The exchange system of the American Dietetic Association was used. Each camper had a snack at 10 a.m., 3:30 p.m. and 8:30 p.m. which included 10 to 25 Gm. of carbohydrate. At meal times each camper used his diet card to select the various foods from a serving table. At each meal one food was weighed; a remarkable improvement in the ability of campers to estimate food quantities was evident over the two week period.

3. Insulin, Duration of Diabetes, Heredity

Table 1 shows the frequency of known heredity, duration of diabetes and insulin dosage on arrival and on leaving camp. It can be seen that there was a known family history of diabetes mellitus in about half, a figure similar to that observed by Stephens and Marble¹ among boys of the same age group. Most of the campers had had diabetes for approximately five years, a few for less than one year and four for over 10 years. In one 14 year old boy diabetes was diagnosed during the first few months of life.

Initially, the insulin dosage was reduced by approximately 20 per cent to allow for the effect of exercise and thus minimize the occurrence of hypoglycemia. Only one of the 40 campers had a hypoglycemic reaction on the first day.

Initially, two campers had been receiving only protamine zinc insulin, 10 NPH only, six Lente only, 11 NPH plus crystalline, three Lente plus crystalline, four mixtures of the Lente group of

insulins, and one NPH plus Ultra-lente. Two were taking phenformin (DBI) plus insulin.

Two of the group were in remission as evidenced by the absence of glycosuria when off insulin; one had entirely normal, and another slightly elevated, two hour postprandial blood glucose concentrations. Both showed diagnostic glucose tolerance curves when tested by either 100 Gm. of carbohydrate (toast plus jelly) or 100 Gm. of glucose. One such example is shown in figure 1. This particular camper, who had normal blood glucose concentrations when on a 2,780 calorie diet (309 Gm. carbohydrate, 116 Gm. protein, 120 Gm. fat), demonstrated a rebound hypoglycemia, with symptoms, four hours after the glucose; this type of hypoglycemia may be an early manifestation of diabetes as shown by Seltzer, Fajans and Conn.⁴ Insulin was continued with both campers.

Each evening the records of all campers were reviewed by the entire medical staff. Changes in insulin dosage were made slowly with several days allowed for stabilization. The nature of camp life such as cook-outs or rain-induced decrease in exercise made it difficult to achieve a constant balance between diet, exercise and insulin. Several campers showed less fluctuation from marked glycosuria to hypoglycemia when insulin was given twice daily.

Glycosuria and Reactions

Each camper tested a freshly voided urine specimen before each meal and at bedtime, using Clinitest Tablets. Glycosuria was graded from 0 to 4 plus in a manner described by Haunz.5 With this semiquantitative method the average glycosuria per camper day during 12 days (initial and final day excluded) was 5.90 with no day-today variation evident. This figure is higher than that reported for a selected group of campers by Haunz.⁵ In my opinion this figure can be significantly reduced at the price of more insulin reactions. Hypoglycemic reactions may interfere markedly with the recreational and educational content of the camp; every reasonable attempt was made to minimize their frequency, and each reaction was treated immediately by the subcutaneous administration of 2 mg. of glucagon. As emphasized by Haunz⁵ this method of treatment has the advantages of minimal upset in diabetic control and a reduced number of feigned reactions. Figure 2 shows the prompt increase in the concentration of blood glucose, and relief of symptoms, within five to 10 minutes after the administration of glucagon. The reaction rate over 12

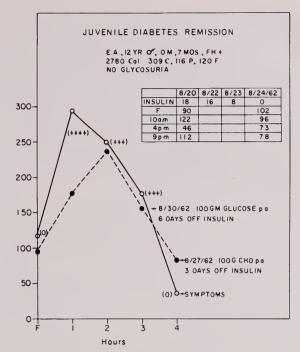


Fig. 1. — The results of oral glucose tolerance tests in a 12 year old juvenile diabetic patient in remission are shown. Note a similar two hour blood glucose concentration with 100 Gm, of carbohydrate and with 100 Gm. of glucose. When glucose was given (8-30-62), the peak level was higher and at four hours typical symptoms of hypoglycemia were present at a time when the concentration of blood glucose was 40 mg. per hundred milliliters. The vertical scale is blood glucose in milligrams per hundred milliliters.

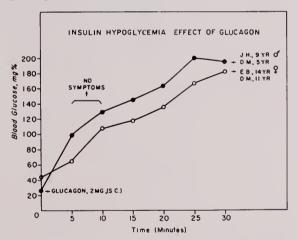


Fig. 2.—This chart shows the prompt increase in the concentration of blood glucose following administration of 2 mg. of glucagon subcutaneously. Symptoms of hypoglycemia were relieved within five to 10 minutes. See text for discussion of advantages of glucagon.

days was 0.20 per camper day, a figure which is an overestimate because all apparent reactions were not documented by blood sugar determination.

At the end of the camp, four campers had excellent, 16 good, eight fair and 10 poor control

of diabetes as judged by the following criteria applied to the last three days of camp. Excellent: no glycosuria and two hour postprandial blood glucose concentrations less than 120 mg. per hundred milliliters; good: 0 to 4.9 glycosuria daily average for last three days; fair: 5 to 8.9 glycosuria daily average for last three days; and poor: 9 or more glycosuria. It is recognized that these are stringent criteria; furthermore the major purpose of this camp was recreational and a better understanding of diabetes.

Laboratory Studies

Facilities were available to make blood glucose determinations on 0.2 ml. of blood obtained by finger puncture; no problems of infection occurred. Dubowski's orthotoluidine method6 was used, which gives a value close to the "true glucose" of the Nelson-Somogvi method. Blood glucose determinations were made fasting and approximately two hours after meals throughout the day during the initial and final camp periods, and as desired to check a particular peak or to document hypoglycemia. It was of interest to note frequent blood glucose concentrations of 50 ml. per hundred milliliters or below without symptoms. Of the routine blood sugar determinations on fasting, 10 a.m., 3:30 p.m. and 8:30 p.m. sample, 42 had a glucose concentration of less than 50 mg, per hundred milliliters; 15 of these campers has hypoglycemic symptoms whereas 27 were without symptoms. Eleven were asymtomatic with blood glucose concentration of less than 30 mg. per hundred milliliters.

Samples of blood were analyzed for glucose by the new "Glucospot" screening method (Worthington Biochemical) and by the orthotoluidine method. The rapid "Glucospot" method consistently gave results within 25 mg. per hundred milliliters with blood glucose concentrations below 200 and within 50 at concentrations over 200 mg. per hundred milliliters. This method was useful in quickly documenting hypoglycemia, especially at night.

Urine Cultures

Since the duration of diabetes in the majority of campers was five to 10 years, or longer, it was thought of interest to determine the incidence of bacilluria. A clean midstream urine specimen was obtained at 6:30 a.m. (no voiding after midnight) and 1 cc. of the undiluted specimen and of a 1:100 dilution was added to a triple sugar agar colony count plate, a blood agar and an eosin-

methylene blue plate. These were read at 48 hours. In 33 of 38 campers the colony count was less than 1,000 colonies per milliliter. Three had between 1,000 and 10,000 colonies per milliliter. One girl had 60,000 (nonhemolytic staphylococcus) and another girl 50,000 colonies (nonhemolytic staphylococcus and enterococcus) per milliliter. This compares with a 1 per cent incidence of over 100,000 colonies per milliliter found by Kunin, Southall and Paquin⁷ in a survey of 1,380 school age girls in Virginia; among 1,647 school age boys there were none over 100,000.

Teaching Activities for Campers

The 40 campers were divided into two groups for the daily formal lecture conducted by a team of physicians, nurses and dietitians. Topics covered included general aspects of diabetes, urine testing, diet, insulins, what is good control, general care and the outlook for diabetic patients. Each day by cabin, the techniques of urine testing, insulin injection including site rotation, diet and foot care were reviewed. On the first day a truefalse examination, similar to one used by Etzwiler and Sines,8 was given with an average score of 16.9 correct; on the twelfth day the average score was 17.8. The most difficult question to clarify was the difference between U-40 and U-80 insulin: 27 of 40 missed this question on the first testing and 19 on the final. The greatest improvement was in understanding the effect of exercise and the significance of consistent glycosuria or aglycosuria. Sixteen of the 41 campers gave their insulin injections when they came; by the end of the first week each camper measured and gave his insulin.

Educational Experience for Medical Staff

Throughout the country many medical and nursing students graduate with minimal or no experience in treating the juvenile diabetic patient. This was true for the medical and nursing students on our staff and also for the two physicians who are medical residents. Daily seminars were conducted which covered the natural history, complications and all phases of treatment of diabetes. To live and work with a group of diabetic patients for two weeks gave meaning to the application of diet, insulin, exercise and emotions in the care of the diabetic patient. For this important reason I think that more camps for diabetic children should be associated with teaching centers. Also, this type of affiliation makes it possible to secure a voluntary staff for a short camping

period, a major reason for limiting the camp to two weeks. The experience at Camp Immokalee emphasizes the desirability of having a medical staff about one and a half times larger than that of the first year; this would allow definite periods of free time for each staff member.

Summary

The method of establishing a summer camp for diabetic children in Florida is described. The importance of utilizing an existing camp facility and camp staff is emphasized. An affiliation with a teaching center provides an optimal medical staff and a unique educational experience for the staff members. With this approach it was possible easily and efficiently to provide complete recreational and educational experience for 41 campers during the first year.

References are available from the author upon request.

J. Hillis Miller Health Center.

Meatus Size in 1,000 Circumcised Children From Two Weeks to Sixteen Years of Age

HENRY G. MORTON, M.D. SARASOTA

The size of the urinary meatus in boys has been discussed by numerous authors, but no series of measurements could be found indicating when a meatus is too small, and when a meatotomy should be performed. Campbell¹ stated: "Although a relatively definite minimal calibre has been established (23 to 26) in adults, in the young, rapid growth permits no such basis. However, in a male of one year a 10F instrument, at five years a 15F, and at 10 years an 18F, will normally pass to the bladder without difficulty unless the meatus is unusually small."

Campbell² again stated that if the meatus is too small, it should be enlarged, and he listed numerous symptoms and conditions that result from a small meatus. Also he observed that despite the usual utter simplicity of diagnosis of meatal stenosis by inspection, and of its treatment by meatotomy, thousands are today suffering serious progressive urinary obstruction because of the failure of their medical advisers to recognize this condition.³

Brennemann⁴ referred to the ammoniacal meatus ulcer, but concluded that a permanent narrowing of the meatus, analogous to a stricture, apparently never occurs even after repeated and prolonged ulcerations.

Since no record of a relatively large group was found in the literature, the following study was made: The meatus was measured in 1,000 circumcised male children ranging in age from two weeks to 16 years. Number 8F, 10F, 12F and 16F metal bougies were used. The largest size that could be inserted through the meatus without causing tears or bleeding was recorded.

Table 1 shows the actual number recorded for each age and size.

Table 1					
Age	8 F	10F	12 F	14 F	16 F
Birth-6 wks.	47	39	5	0	0
6 wks4 mos.	9	26	5	5	0
4 mos9 mos.	5	18	17	0	0
9 mos15 mos.	6	26	18	7	1
15 mos2 yrs.	4	13	19	4	1 2 1 2 3 5 6 3
2 yrs.	12	42	27	9	1
3 yrs.	11	29	26	11	2
4 yrs.	2	28	28	8	3
5 yrs.	5	34	29	11	5
6 yrs.	4	22	27	5	6
7 yrs.	3	15	17	6	3
8 yrs.	4	16	15	15	2
9 yrs.	2	11	21	12	6
10 yrs.	1	12	13	16	2
11 yrs.	0	3	18	9	8
12 yrs.	0	2	12	6	13
13 yrs.	1	1	4	3	11
14 yrs.	0	0	0	5	21
15 yrs.	0	0	1	1	19
16 yrs.	0	0	0	0	8

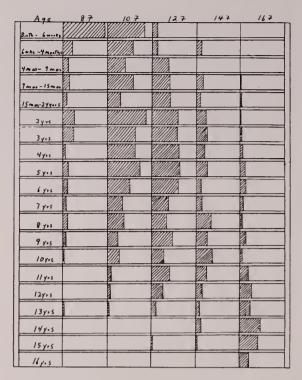


Figure 1

Ta	ы	ما	9
- 12		4.0	6

Age	8 F	10F	12 F	14F	16 F
Birth-6 wks.	51%	42%	5%	0%	0%
6 wks4 mos.	20%	57%	11%	11%	0%
4 mos9 mos.	1%	45%	42%	0%	0%
9 mos15 mos.	11%	44%	31%	12%	1%
15 mos2 yrs.	9%	30%	45%	9%	4%
2 yrs	13%	46%	29%	9%	107
3 yrs.	13%	36%	32%	13%	2%
4 yrs.	2%	40%	40%	11%	4%
5 yrs.	5%	40%	34%	13%	5%
6 yrs.	6%	34%	42%	7%	900
7 yrs.	6%	34%	38%	13%	6%
8 yrs.	7%	30%	30%	28%	307
9 yrs.	3%	21%	40%	23%	11%
10 yrs.	2%	27%	29%	36%	4%
11 yrs.	0%	7%	47%	23%	21%
12 yrs.	0%	6%	36%	18%	39%
13 yrs.	5%	5%	20%	15%	55%
14 yrs.	0%	0%	0%	19%	80%
15 yrs.	0%	0%	4%	4%	90°%
16 yrs.	0%	0%	0%	0%	10000

Figure 1 demonstrates the trend of enlargement that takes place with growth. The shading is equivalent to the numerical numbers in Table 1.

Table 2 indicates the percentage for each age and size.

It is noteworthy that an acute cystitis was encountered in only one of these boys during the

period of this work. It occurred in an eight year old child with a meatus admitting an 8F dilater. The infection cleared with medication, and a meatotomy, though advised, has not been performed.

During this same period of time 50 females were measured, some routinely, but mainly because of symptoms of cystitis or enuresis. Of this group 23 had acute cystitis. Generally, the meatus in the female is larger than in the male. As an office procedure, the female meatus is much more difficult to measure, and practically impossible to measure in a child under six months of age. The number measured and the difficulties involved make a chart of this work unrealistic at the present time. The ratio of one case of cystitis in a male to 23 cases in females compares favorably with that reported by others. 5,6

Time and again during this work it was realized that the eye is no judge of the size of the meatus. Only by passing a sound could one be sure of the meatal size.

With normal growth and development, the meatus enlarges and in almost all instances is adequate in size. In a few there is definite need for a meatotomy, and in this group the procedure should be performed.

Summary

Normal meatal measurements are given for circumcised males whose ages ranged from birth to 16 years.

The ratio of cystitis in males and females in this study was 1 to 23.

References

- Campbell, Meredith F., editor: Urology, Vol. 2, Urology in Infants and Children, p. 1550, Philadelphia, W. B. Saunders Company, 1954.
 Campbell, Meredith F.: Male Reproductive System, in Practice of Pediatrics, Brennemann & McQuarrie, vol. 3, chap. 30, p. 8, Hagerstown, Md., W. F. Prior and Co., 1960.
 Campbell, Meredith F.: Stenosis of the External Urethral
- Inc., 1900. Campbell, Meredith F.: Stenosis of the External Urethral Meatus, presented at the annual meeting, American Association of Genito-Urinary Surgeons, Stockbridge, Mass., June 11,
- 1943.
 Brennemann, Joseph, M.D.: The Ulcerated Meatus in the Circumcised Child, presented at the annual meeting of the American Pediatric Society, May 30 and 31, June 1, 1920. Kunin, C. M.; Zacha, E., and Paquin, A. J. Jr.: Urinary Tract Infections in School Children, I. Prevalence of Bacteriuria and Associated Urologic Findings, New England J. Med. 266:1287-1296 (June 21) 1962.
 Kunin, C. M., and Halmagyi, N. E.: Urinary-Tract Infections in School Children. II. Characterization of Invading Organisms, New England J. Med. 266:1297-1301 (June 21) 1962.

1950 Arlington Street.

Primary Septic Bursitis

ANDRE MARCHILDON, M.D., ROBERTA R. SLONIM. M.D.. HARVEY E. BROWN JR., M.D., AND DAVID S. HOWELL, M.D.

Septic bursitis without obvious primary focus or definite precipitating cause apparently is rare, with reports of previous cases difficult to find. Extension of bacterial involvement from distant sites to the bursae has been reported in meningococcal disease,1 tularemia,2 brucellosis,3 tuberculosis.4 Septic bursitis also may arise through spread of a purulent process from neighboring joints or infected wounds.

During the last five years, six patients have entered the hospital complaining of swelling and pain over the knees or elbows, localized respectively to the olecranon and suprapatellar bursae. Pathogenic organisms were isolated from the bursae in five. Potential errors in diagnosis and management are demonstrated by the following case histories.

Report of Cases

Case 1.—A 25 year old salesman entered the hospital on Jan. 21, 1959. Four weeks previously he was awakened from sleep at night by pain in the left elbow. The following morning this elbow, which had become red and swollen, was aspirated by his local physician, who made a diagnosis of gouty arthritis. Without trial of colchicine, a 10 day course of a cortisone derivative was administered. Later the patient remembered that within a week before the onset of symptoms he had scratched a small furuncle on his left forearm.

Examination.—Vital signs and general examination gave negative results except for the left elbow, which was erythematous and swollen in the region of the olecranon bursa. Cultures of the bursal aspirate revealed a heavy growth of Staphylococcus aureus, coagulase-positive, sensitive to several antibiotics, including penicillin. No pathologic change was seen in elbow x-rays, and serum uric acid

was 5.5 mg. per hundred milliliters.

Treatment.—The patient received procaine penicillin, 500,000 units, intramuscularly at six hour intervals for 10 days. By the sixth day, there was moderate reduction of heat, swelling and tenderness, and he was well on the tenth hospital day.

Case 2.—A 14 year old Negro male was admitted to the hospital on Nov. 24, 1958, complaining of pain in the right knee, which was punctured by a nail two days prior to admission. Within 12 hours, pain, limited motion and

swelling developed.

Examination.—The temperature was 100 F.; swelling, heat and erythema were localized to the area overlying the prepatellar bursa of the right knee. The remainder of the examination gave negative results. On aspiration there was thick, milky fluid containing 250,000 white blood cells per cubic millimeter, with a differential count of 75 per cent polymorphonuclear leukocytes. Smear and culture of the fluid for pathogenic bacteria were negative. Throat culture disclosed a heavy growth of Staph. aureus, coagulase-positive, sensitive to penicillin.

Treatment.-The patient received tetanus toxoid and then procaine penicillin, 600,000 units, and streptomycin, 0.5 Gm., intramuscularly, twice daily for 10 days. During the first five days there was steady improvement, and

on the sixth day he was asymptomatic.

Case 3.—A 28 year old physician was admitted to the hospital on Feb. 12, 1959, with a swollen, red, painful left elbow. For five months the patient had noticed intermittent attacks of furuncles or pustules on the extremities; culture on each occasion yielded Staph. aureus. As with the pustular lesions, the present attack began in a fulminating manner.

Examination.-No positive features of a general medical examination could be elicited other than a temperature of 101 F. The region of the left olecranon bursa (fig. 1) was erythematous, swollen, exquisitely tender, and fluctuant, with splinting of the elbow because of pain. The fluid was too thick for adequate cell count, but a smear revealed 99 per cent polymorphonuclear leukocytes. Cultures of the bursal fluid on two separate aspirations yielded a heavy growth of Staph, aureus, coagulase-positive. At the same time, culture of purulent material from a furuncle on the right arm revealed an identical organism with a similar pattern of antibiotic sensitivities. X-ray of the elbow showed no evidence of bone damage. A complete blood count, urinalysis, serum protein electro-phoresis, and glucose tolerance test were within normal

Treatment.—The patient was given chloramphenicol. 500 mg., and erythromycin, 250 mg., at six hour intervals, concurrent with nystatin, 500,000 units, at eight hour intervals for the first five days. Erythromycin was discontinued because of skip eruption, but the other two agents were administered for a total of 11 days. On the fourth hospital day, the left olecranon bursa was tapped and irrigated with saline containing 500 mg. of streptomycin. By the sixth hospital day the fever had subsided, and the left elbow was free of symptoms and signs.

Case 4.—A 50 year old white male, a chronic alcoholic, was hospitalized on July 19, 1959, because his left elbow had been painful and swollen for three days. He had been on a drinking bout for several days. Noteworthy were his alcoholism of 25 years' duration, and at least five episodes of delirium tremens. No history of arthritis or

rheumatism could be elicited.

Examination.—The temperature was 102 F., the pulse rate 120, and the patient obviously was in pain. conjunctivae were injected; teeth, carious; lung fields, clear; and except for tachycardia, the heart findings were not remarkable. None of the usual stigmata of chronic liver disease was present. Recently healed cigarette burns were noted on the left index finger, and on the superior third of the left arm. There was a fluctuant, erythematous swelling at the site of the left olecranon bursa. Laboratory studies, including a complete blood count, urinalysis, fasting blood sugar, hepatic function, and serologic agglutination tests, as well as chest and elbow x-rays, were within normal limits. Serum albumin was 2.73 Gm. per hundred milliliters with a normal distribution of globulins. Purulent fluid aspirated from the left olecranon bursa provided a heavy growth of Diplococcus pneumoniae, sensitive to tetracycline, but resistant to a variety of other antibiotics. Three blood cultures were negative.

From the Department of Medicine, University of Miami School of Medicine, Jackson Memorial Hospital, Miami, and U. S. Veterans Administration Hospital, Coral Gables.



Figure 1

Sputum culture was negative for acid-fast bacilli, and a throat culture grew only alpha streptococci and neisseria.

Treatment.—The patient received procaine penicillin, 600,000 units, intramuscularly at six hour intervals for seven days with gradual improvement until a skin rash developed, necessitating temporary interruption of treatment. Thereafter, he received tetracycline, 250 mg., at six hour intervals for five days. After eight doses, there was no further evidence of infection.

Case 5.—A 42 year old male was under cortisone derivative treatment for atopic eczema of three years' duration. He was seen in the Arthritis Clinic on Sept. 25, 1959, because of swelling, pain and tenderness over the right elbow for a week. There was no history of rheumatism, or any recent trauma to the elbow.

Examination.—Swelling and heat over the posterior aspect of the right elbow were noted. Aspiration showed purulent material, and a smear revealed predominant polymorphonuclear leukocytes. A culture grew Staph. aureus, coagulase-positive, sensitive to tetracycline. X-rays showed no lesions.

Treatment.—Declomycin, 125 mg., at six hour intervals for 14 days was prescribed. During this period, heat, erythema and swelling diminished. Soft tissue enlargement remaining at the end of treatment was not in evidence at the three week follow-up.

Case 6.—A 30 year old white male roofer was admitted to the hospital on Jan. 11, 1960, presenting with heat, redness and swelling of the right knee, beginning abruptly four days earlier. He related no episodes of knee injury or arthritis. On the first day of his symptoms, a local physician treated him for acute gouty arthritis.

Examination.—The temperature was 100 F. The right knee was hot, swollen and acutely tender in the region of the prepatellar bursa. There were large right inguinal lymph nodes.

Aspiration of the right suprapatellar bursa revealed 2 ml of thick, purulent material which, upon culture,

grew Staph. aureus, coagulase-positive, sensitive to a variety of antibiotics. Chest and joint x-rays displayed no abnormality.

Treatment.—Albamycin, 500 mg., and erythromycin, 500 mg., were given at six hour intervals for two weeks. Incision and drainage of the bursa became necessary because of further elevated temperature and worsening symptoms on the second hospital day. Open drainage was continued for one week, and then the wound was allowed to heal, uneventfully.

Discussion

Each of the six patients was male with involvement of either the olecranon or prepatellar bursa, and Staph, aureus was cultured from four. All were males between 20 and 40 years of age.7 This result is in contrast to findings in patients with septic arthritis with staphylococcus as reported by Ward, Cohen and Bauer,⁵ who noted an approximately equal sex distribution with peaks in age ranges under 12 and over 48 years. General medical evaluation of the patients at the time of contracting this illness indicated that they were vigorous, and except in case 5, none had chronic diseases. In case 2, the organisms undoubtedly entered the bursa through a puncture wound. The source of infection is speculative for the others. In regard to cases 1 and 3, it is possible that isolated pustular lesions supplied organisms which disseminated to the bursae. Only the patient in case 3 had a history of repeated superficial infections, which were usually caused by staphylococci; serum protein electrophoresis on three occasions failed to reveal abnormal patterns or lack of gamma globulin. None of the patients exhibited glycosuria. Fasting blood sugar levels obtained in cases 2, 3 and 4 were within normal limits. It is suspected that the chronic alcoholism in case 4 and the long term steroid treatment for dermatitis in case 5 were predisposing factors in the bacterial invasion of the bursae. No local infections or openings in the skin were noticed directly over the bursae. Accordingly, hematogenous or lymphatic spread from a distant site is more likely. Small repeated traumatic episodes involving the knees and elbows, frequently unnoticed in daily activities, might serve as a localizing factor. Septic arthritis or purulent synovitis did not seem to be the initiating cause, although in two patients, heat, redness and swelling appeared on external examination to extend into the region of the synovia. Careful study of each patient's joint x-rays and palpation of the articular margins failed to give evidence of effusion in the articular spaces.

Like gouty attacks, the illness began abruptly at night in two patients, and in all, the inflammation was restricted to one joint area. Nonseptic olecranon bursitis is common in gout, and the usual diagnostic measures, including a trial of colchicine, should be employed in doubtful cases. Historical or current evidence of the disease in other regions may be expected in most gouty patients presenting as described.

Acute single attacks, such as described here, should be readily distinguished from chronic recurrent nonseptic prepatellar or olecranon bursitis (housemaid's knee and miner's elbow).4 Upon suspicion of a septic bursitis, immediate aspiration, smear and cultures of the fluid for the predominating organism, mycobact, tbc, and fungi are indicated. Prompt, appropriate treatment with antibiotics, determined by sensitivity of the organism isolated, cured these six patients, but one required surgical drainage, in addition. With the rising incidence of staphylococcus infections⁶ it is doubtful that this entity will remain as rare as review of the literature would imply. Such patients serve to emphasize the potential seriousness of failing to recognize sepsis and the obvious dangers of treating them with anti-inflammatory steroids.

Summary

Six cases are reported in which acute septic bursitis developed without evidence of associated arthritis. The olecranon or prepatellar bursae were involved with an abrupt, intense inflammation of short duration, caused by Staph, aureus in at least four of the cases. In five cases there was response within six to 14 days to antibiotic treatment, and in one case surgical drainage was required. More frequent reporting of this entity may be anticipated along with the rising incidence of staphylococcal diseases.

References

- References

 1. Balboni, V.: in Hollander, Joseph Lee, editor, Arthritis and Allied Conditions, Philadelphia, Lea & Febiger, 1960, chap. 58, p. 999.

 2. Hench, P. S, and others: Rheumatism and Arthritis; Review of American and English Literature for 1940, Ann Int. Med. 15:1002-1108 (Dec.) 1941.

 3. Kelley, P. J.; Martin, W. J.; Schirger, A., and Weed, L. A.: Brucellosis of the Bones and Joints, J. A. M. A. 174:347-353 (Sept.) 1960.

 4. Jaeger, H. W.: Meningocosis del Aparato Locomotor, Arch. Soc. Cirujanos Hosp. 12:305-319 (Dec.) 1942.

 5. Ward, J.; Cohen, A. S., and Bauer, W.: The Diagnosis and Therapy of Acute Suppurative Arthritis, Arthritis Rheum. 3:522-535 (Dec.) 1960.

 6. Shands, Alfred R., and Raney, Richard B.: Handbook of Orthopaedic Surgery, St. Louis, The C. V. Mosby Company, 1957, p. 583.

 7. Rogers, D. E.: Staphylococcal Infections, DM; Disease-a-Month, April 1958, p. 3.

Jackson Memorial Hospital.

Volume 50 of The Journal, which began with the July issue, will end with the December, 1963, issue, allowing only six instead of the usual 12 numbers. The House of Delegates in session at the Annual Meeting approved the resolution, originating within the Hillsborough County Medical Association, which directed that each volume begin with the calendar year in order to correspond with the other activities of the Florida Medical Association.-T. M.

The Importance of Skin Cover in the Injured Hand

There are few injuries in our society that cause more economic disability than those of the hand. It is the laborer or skilled worker who most frequently suffers hand injury and whose livelihood depends upon normal hand function. Because the hand plays such an important role in all daily activities and is the organ responsible for discriminating touch, it is essential that the repair of the injured hand restores maximum possible function.

In working toward restoration of function a plan of treatment is essential. Key points are: the primary repair of vital structures, the early restoration of joint motion and the prevention of scar. These three points will be discussed separately and the prevention of scar in more detail.

With the availability of antibiotics and with the techniques of modern surgery and repair as taught by Dr. Bunnell and his followers, the primary repair of vital structures is not only possible but is in many cases advisable. Fractures may be internally fixed; tendons, except those in the flexor sheath, can be sutured, and nerves at least coapted by a single suture.

The restoration of function depends upon the restoration of joint motion at three weeks postinjury and the prevention of edema in the injured hand throughout the entire recovery period. Edema can be prevented by rest of the injured part, always in a position of function, compressive dressings and elevation during the post-injury phase. Ideally, motion should be started when post-injury pain subsides and preferably before three weeks. It is frequently necessary to immobilize hands three weeks for fracture and tendon healing. At three weeks these structures can be gently mobilized if primary healing has been accomplished. Beyond three weeks joint capsules contract, ligaments around joints shorten, and adhesions, which cannot be easily stretched, form between tendons and their surrounding structures. All management of the injured hand, therefore, should be aimed at the restoration of painless motion, preferably active motion, beginning about three weeks post-injury.

From the onset the surgeon must aim his treatment at the prevention of scar tissue. Scar tissue in the deeper structures of the hand pervades all spaces, surrounds joints and binds their capsules, and constricts nerves. Scar tissue in the skin contracts and limits joint function. It becomes painful, and does not tolerate pressure and friction sufficiently for normal use. In the very simplest of terms the prevention of scar tissue depends upon the prevention of granulation tissue. Granulation tissue is nothing other than embryonic scar which upon maturity contracts and becomes dense. Thus the prevention of granulation tissue depends upon healing by first intention and the prevention of infection.

Elimination of infection requires cleaning the contaminated wound and converting it to a surgical wound which can be closed primarily. To accomplish this objective, all foreign material, necrotic tissue or tissue which may become necrotic must be removed by sharp dissection. Hematoma can be removed by copious irrigation which should penetrate every crevice of the wound. Such a wound must be closed carefully without tension, without dead space and without the formation of hematoma. This means the accurate apposition of skin edges and deeper structures by means of careful fine suturing and the avoidance of unnecessary trauma to skin edges. Such suturing technique involves frequent changes of needles so that they are sharp, and the use of skin hooks. If forceps must be used, they should be used with the jaws together as pushers and not as pinchers of the skin edges.

When there is adequate skin, such wounds should be closed by primary apposition of skin edges. Skin adequate for such closure is not already dead and will not become dead because of tension or a decreased blood supply. When there is inadequate skin for primary cover, skin from other sources must be obtained. It is much wiser

to use grafting techniques in any situation where there is questionable viability.

The easiest method of obtaining skin from another source is of course the split graft. Small to moderate split grafts of skin can be taken for use in hand repair from the forearm if preoperative planning has included preparation and draping of this area. These grafts can usually be taken with tongue blades and a straight razor and can even be taken with a local anesthetic. The survival of split skin grafts is dependent upon their gaining adequate blood supply from the recipient site. In the hand it should be remembered that adequate blood supply for split thickness skin grafts is not available from tendons or tendon sheaths, bone, joint capsules or nerves.

If, therefore, any of these four tissues are exposed in the depths of a hand wound, skin must be provided in a manner in which the blood supply accompanies the transferred skin. By necessity this must consist of a flap or a tube-pedicle. The latter has only occasional use in the primary repair of a hand wound. The flaps which are available for the repair of the hand wound are the cross-finger flap, the cross-arm flap which provides skin very near the consistency of normal hand skin, and the abdominal flap. The thenar flap and the total burial of the hand in the ab-

dominal wall should be mentioned as not advisable, and leading to many complications. Local rotation and advancement flaps are possible chiefly on the dorsum of the hand or to provide skin cover at the radial and ulnar border from the dorsum of the hand. Such flaps are difficult if not impossible in the palm or the flexor surface of the fingers because of the binding underlying fascia which limits skin mobility.

Thus in the repair of the injured hand the primary skin cover, preferably by a direct suture or by means of grafts and flaps, is very important. When such adequate skin cover is obtained as part of the primary repair of the injured hand, the course which follows becomes smooth for it is beneath such skin that the prompt healing of vital structures with minimal scar formation can be accomplished. It is intact healthy skin that prevents the invasion of bacteria that results in infection, granulation tissue and the end products of scar which limit function. Lastly, it is the living skin which maintains the internal environment where secondary repair of vital structures can be carried out if necessary.

RICHARD M. FRY, M.D.

ASSISTANT PROFESSOR OF SURGERY
UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE
GAINESVILLE

President's Page

Accentuate The Positive

Old Song: "You've gotta accentuate the positive, eliminate the negative. (Chorus) Latch on to the affirmative, and don't mess with Mr. In-Between."

Some years ago, while traveling in the car, we heard a radio commentator relate a simple little story which has lingered in memory. It is impossible to give proper credit, because the name of the program and of the speaker are not known. He was emphasizing the point that, in life, we must overcome one obstacle at a time. The motorist must read the lights properly as he approaches an intersection. If the railway engineer waited for every signal to be green before he started on a journey, the trip would never begin. He must take one light at a time. Thus, we live one day in accordance with what's right. If a young couple, beginning married life, could foresee all of the obstacles and problems which would be encountered, the wedding would, very likely, not take place. If every new housewife anticipated the meals which she must personally prepare, the dishes to be washed, the daily chores to be done, she would, probably, not be as enthusiastic. Persistence is essential. We encounter one problem at a time, achieve one success at a time, undertake one mile with a single step.

The analogy is obvious. In Medicine, we are confronted with many problems. It is impossible to solve them all at once. Our resources are better now than formerly: more effective drugs; daily opportunities to prevent, as well as to heal, disease; finer techniques in diagnosis and management. Thus, we may work in preservation of the health of our patients, or for the cure of their illnesses, and not for some socioeconomic method of distributing medical services. The individual responsibility is important. The relative issue is freedom. So, our efforts must be devoted toward overcoming one obstacle at a time. But the basic goal of the physician, better care of the

patient, is thus fulfilled.

Newspaper articles, magazines and book reports recently have pointed out some unhappy circumstances involving modern medical practice. Uninformed people are attempting to force social medical reforms in our legislative bodies. One of our best recourses, in response, is to accentuate the accomplishments, and stress the many advantages, of modern medical care over those of earlier years. Definite attainments in the prevention and control of infections; addition of years to life expectancy; improved surgical procedures; development of many new drugs through research—all of these factors represent progress. Many of the answers are not yet known. But it is a continual process of learning and productive activity, of concentration and of effort. Meanwhile, our patients want our individual interest and understanding, as physicians.

Emmet John Hughes, in the preparation of his book, "The Ordeal of Power", reported a comment by President Eisenhower: "Leadership is not hitting people over the head. That's assault! Leadership is persuasion, and conciliation, and education, and patience. It's long, slow,

tough work. That's the only kind of leadership I believe in."

Each generation of physicians is the subject of criticism. The horse and buggy doctor did a better job than his predecessors, attended his patients well in the light of the scientific accomplishments of that era, and with a great deal of personal supervision. Yet it would be foolish to hearken back to his criteria in the light of modern knowledge. People recognize progress, but they are realistic. And they are examining carefully some cherished images of the past.

We must respond to criticism, not with complacency, but with definite facts to inform the

public (our patients) about what we believe and what we are attempting to accomplish:

1. We must tell the public about advances in American medicine during recent years, and the advantages presently offered. Broad knowledge involves specialization, and there is importance in becoming especially skilled in some phase of medicine or surgery. Proper care of the patient necessitates, in some instances, electrocardiograms, electroencephalograms, laboratory reports, hormone assays, and other special services, for best results. Costs, then, have gone up. But, what a bargain in results!

2. Let's inform the laymen about our own plans for care of the indigent; about implementation of the Kerr-Mills Law in our state for medical assistance to the aging; about the constant fight we are waging against quackery, and why. Incidentally, it would be well to state that taxation for locally controlled facilities has been less than that for some of the broad, socialistic schemes of federal do-gooders. We might, also, emphasize the importance of voluntary health insurance programs in helping to finance the costs of illness, and the role played by physicians,

through service, in making these programs possible.

3. Much of the criticism directed against the medical profession is based upon misinformation and misunderstanding. The physician, serving as a leader in community affairs, can clarify misconceptions and provide accurate information. Recently a comment in the Whitesboro (Texas) News stated: "The trouble with many people in trying times is that they stop trying." This should never be true of the medical profession. We have much to offer. And one of our responsibilities is a try for better understanding. By accentuating the positive we may, individually, help to eliminate the negative.

Women wo inclian



Psyche and Soma

The enigma of psyche and soma is ever a fascinating field for conjecture. Fortunately scientific inquiry into this field is increasing in breadth and depth. A high percentage of mental health funds is currently devoted to one fragment or another of this great puzzle. The Armed Forces are leaders in several phases of investigation. The drug firms, in their quest for substances to affect the psyche, make an important contribution in this field. Many specialists are involved—among them, the physiologist and biochemist, the psychologist and sociologist, the electroencephalographer and the clinician.

It has now been more than a decade since Meduna, in an address at St. Elizabeth's Hospital, told how, after his early work in Budapest on convulsive therapy had won such acclaim, a friend asked what he was planning to do now. When Meduna replied he was going to find out how the treatment accomplished its results, the friend advised him to go fishing, for soon the great research centers in America would find the answer. "But still," said Meduna, working in Chicago in one of those great centers, "we have not found out."

From early times the effect on the psyche of castration of the male animal or human has been recognized and still we do not understand the intricacies of how personality is affected by this hormonal imbalance. In our impatience for more exact knowledge it seems a very long time since the early work of such men as Cannon and Pavlov. Forty years seems an incredible time for insulin to have been used effectively in the treatment of psychic disorders without a precise answer as to the mechanism of its actions. What are the mechanics of mother love? What neurochemical processes and what cellular structures are involved? By what mechanisms are memories stored, forgotten and recalled? By what neural pathways or by what subtle chemical change does a buried memory affect the bodily processes? The physiology of fear is fairly well understood, but what are the exact processes within the cerebrum? By what disturbance of chemistry is a man or woman permanently rendered unable to have a small amount of alcohol in any form, even by injection under anesthesia, without an intolerable craving for more? How do genes, a deprived childhood, or stresses of life bring about paranoid delusions or threatening voices? And exactly where and how can a few small pills in 24 or 48 hours dispel the delusions and hallucinations?

While the psychiatrists are increasingly intrigued with new discoveries in the organic processes of the nervous system, the general field of medicine is increasingly aware of the influence of emotions on bodily processes. As answers are sought, the inseparability of psyche and soma becomes more obvious and psychiatry becomes more and more closely allied to general medicine.

Sullivan G. Bedell, M.D. Jacksonville

Summer Camp for Diabetic Children

As summer wanes, young campers from all over our vast country are packing their trophies including snakes and frogs along with their somewhat bedraggled clothing to return home. At this same time some 60 children in our state are getting ready to attend the second session of a camp for diabetic children which is to be held at Camp Immokalee the last two weeks of this month.

Camp Immokalee is the oldest camp in Florida and has been under the direction of the Y.M.C.A. for over 50 years. Much of the success of our first experience in providing a camp for diabetic children must be given to the excellent facilities and well trained staff of that organization.

Although the report on the first year's camping experience which appears elsewhere in this issue of The Journal is primarily concerned with its medical aspects, it should be emphasized that in principle the camp was conducted much the same as any other camp and that this was the intent of the committee in its establishment.

Despite the "clearly established" value of summer camps for children with diabetes, there are those who still question their desirability on the grounds that they tend to accentuate for these children the already keenly felt differences from their schoolmates and that they favor a genetic progression of the disease.

Such genetic implications cannot be disregarded when we consider such interesting facets of this rapidly advancing and consuming discipline as the increased occurrence of diabetes in blood group A and the apparently rising incidence of those diseases with A-association such as carcinoma of the uterus.

The value of glucagon in such a camp is obvious. Fortunately, the occurrence of insulin resistance in the juvenile diabetic patient is practically unknown, and although an insulin antagonist has been demonstrated in the albumen fraction in young persons with uncontrolled diabetes, it apparently does not alter insulin sensitivity. The hour-by-hour fluctuations in the insulin needs of the growing child are remarkably

more capricious than in the adult, however, and this fact alone would tend to give the young doctor living at such a camp a priceless experience.

The establishment of a permanent camp site nearer the J. Hillis Miller Health Center has been proposed and should be considered for the future. Certainly it would lend itself well to the medical safety of the camper as well as enhance the already excellent resident program of the University of Florida's Teaching Hospital. It would also facilitate research which in turn could attract financial support without adding another disease-of-the-week drive for public funds. For the present, however, it would seem wise to continue the camp at Immokalee where most, if not all, expenses can be met by the individual camper, certain sponsors and the A. D. A. Campership Fund.

Well over a year of planning with meetings and reams of correspondence preceded the opening of Florida's first camp for diabetic children, but I am sure that each member of the committe thinks as I do that the success of this venture was well worth the effort. It will be interesting to watch this camp grow in size and importance under the guidance of the Florida Diabetic Association.

MATTHEW E. MORROW, M.D. JACKSONVILLE

Smoking Habits in Lake County

The cigarette-smoking father and mother can be partly responsible for increasing lung cancer in their children. They are doing this unknowingly and in spite of the fact that lung cancer is not directly inherited. Children whose parents smoke are more apt to have lung cancer caused by smoking than are children of nonsmoking parents because they are more likely to smoke.

Lake County had 456 senior high school students who were given an opportunity to fill out a questionnaire on the smoking habits of themselves and the smoking habits of their parents. Ninety-seven per cent (442) returned the questionnaire completed. Many made enlightening comments. Twenty-nine per cent admitted that they smoked cigarettes (21 per cent of the boys and only 8

per cent of the girls). A similiar study made on the Pacific Coast revealed that 61 per cent of the high school seniors (35 per cent of the boys and 26 per cent of the girls) smoked.

In 113 homes of members of the Lake County senior class neither parent smoked. In 201 homes only one parent smoked cigarettes while in 128 homes both parents were reported to be smokers.

One salient factor stands out in this study: In a home where neither parent smoked there was only one chance in 11 that the child would be a smoker by the time he or she reached the fourth year in high school. If one parent used cigarettes, there was one chance in four while if both parents were addicted to the filthy weed, the possibility had increased from one in 11 to one in three, a finding statistically significant beyond any question.

Those who once smoked, but had quit, gave the following reasons and in the order listed: (1) athletics and school; (2) associates (dates, friends and parents); (3) church; and (4) miscellaneous (costly, dirty habit, mother died of cancer, et cetera).

All of the seniors except one knew of the cause-effect relationship between lung cancer and cigarette smoking. Some did not believe it, but they were aware that such a theory did exist.

Incidentally, these findings do not parallel the findings pertaining to the chronic alcoholic. There seems to be little factual evidence that an alcoholic parent is more apt to have an alcoholic offspring than is the nonalcoholic parent.

The preponderance of scientific evidence indicates that there is a direct relationship between lung cancer and cigarette smoking. Further, the younger a person is when he begins to smoke, the more likely he is to have cancer of the lung.

The ages of this group when they began smoking ranged from 10 to 17 years. No statistical significance was or could be elicited from this study regarding scholastic endeavor since we could not determine the sequence, 'Do they smoke because they get low grades or do they get poor marks because smoking decreases cerebration?'

Persons who smoke two packs of cigarettes per day for a lifetime have a lung cancer rate that is 20 times higher than that of a nonsmoker and one out of 10 such smokers will die of lung cancer.

If we are to reduce the number of cigaretteproduced lung cancers, it would appear that we should start with the parents. Education aimed at our 12 to 15 year olds may be a little late, at least, late for their own generation.

J. BASIL HALL, M.D. TAVARES

RD—Chronic Cough—Shortness of Breath

The activities of voluntary health agencies encompass patient care, research, and education, and it is well to consider that in the case of each organization the emphasis varies according to its own established policies. The relative importance that one gives to each facet depends to a large measure on his own interest. Surely, it can be said without fear of contradiction that all three activities deserve emphasis.

One agency that has traditionally concentrated in the areas of education—for both physicians and the public—is the National Tuberculosis Association. Its "anti-spitting" campaigns of years past, its pointing up the problems of nutrition in the "high risk" tuberculosis group, its campaigns to establish public health facilities are some of the many educational activities that can be mentioned. Now, the National Tuberculosis Association, in conjunction with its state and local affiliates, is engaged in another nationwide educational campaign which in scope and intensity outstrips any other that it has ever attempted.

What is RD? Is this another instance of bureaucratic initial juggling? Is this something dreamed up by advertising agencies? Is this something to glorify the name of entertainers who must

constantly keep themselves before the public? RD is a convenient abbreviation for Respiratory Diseases, including, among others, emphysema and chronic pulmonary suppuration. The increasing interest and concern of many investigators in this area should be apparent to anyone who peruses the voluminous and ever mounting medical literature on these subjects. Indeed, significant contributions to the understanding of the etiology and pathogenesis of emphysema are being made by several physicians in our state. Among the etiologic factors under close scrutiny is air pollution. It is well known how difficult it is to convince responsible officials that the harmless-looking smoke that hovers aloft, to say nothing of the invisible particles, may be extremely dangerous poisons to persons with various pulmonary problems. It is hoped that one of the results of the RD campaign will be an increased awareness of the problems of air pollution—it exists even in the sparkling blue skies of Florida.

The etiologic roles of viral respiratory infections and of cigarette smoking are additional problems being intensively studied. If the public is made aware of the magnitude of the problem of emphysema and of other chronic diseases of the respiratory tract, then no doubt more stringent public health measures will result. More important for the individual so affected, it is hoped that as a result of the Chronic Cough—Shortness of Breath campaign, he will now seek medical advice for his previously neglected "cigarette cough" and for his dyspnea, which he attributes to aging, and thus avail himself of newer preventive and therapeutic measures.

But why, one asks, also educate the physician? Chronic lung disease is chronic lung disease and it has not changed since the days of Laennec. But does the physician know of the problems of diagnosis, of the newer techniques of diagnosis, of the newer therapeutic measures, and, most importantly, is he aware of the sources to attack to prevent this crippling malady. To help answer these questions is the aim of the RD campaign for physicians.

Is this another example of a voluntary health agency "looking for a disease to conquer" or, indeed, looking for a "raison d'etre"? This can be answered categorically in the negative. The National Tuberculosis Association has always been concerned with all diseases of the respiratory tract. Now that tuberculosis no longer assumes its former magnitude as a public health problem, it is only natural that the Association expand its preexisting interests—and this is precisely what it is doing. Hence, the increasing emphasis on nontuberculous diseases of the respiratory tracthence the RD-Chronic Cough-Shortness of Breath campaign. Indeed, there is a raison d'etre for the NTA, for RD. Parenthetically, this is not a fund-raising campaign. To participate actively one needs only to listen, read, and think.

MAX MICHAEL JR., M.D. JACKSONVILLE



American Medical Association 112th Annual Meeting Report of Delegates

At the Annual Meeting, held in Atlantic City on June 16-20, 1963, Dr. Edward R. Annis of Miami assumed office as President of the American Medical Association. His outstanding record as a spokesman for American Medicine assures distinguished leadership throughout the period of his administration. His achievements are a source of great pride to his Florida colleagues, and they accord him their loyal support. In his inaugural address, Dr. Annis stressed the importance of maintaining an attitude of individualism among the physicians of America and urged them to have the courage and individuality to fight for all political, economic and prolessional freedoms. Later, he declared that "now, more than ever before, there is an obligation for all of us to waive or at least to minimize any differences between or within regions, specialties or organizations and to stand together on fundamental principles of medical care and medical practice, of enterprise and of freedom for which our great Association has striven in the past 116 years.'

Dr. Norman A. Welch of Boston was named President-Elect and will succeed Dr. Annis at the June 1964 meeting in San Francisco. Dr. Burns A. Dobbins Jr., of Fort Lauderdale was elected to membership on the Council on Medical Service. The AMA 1963 Distinguished Service Award was voted to Dr. Lester R. Dragstedt of Gainesville, Research Professor of Surgery at the University of Florida College of Medicine, for his achieve-

ments in the fields of education, research and practicing surgery. The meeting attracted 12,924 physicians, with final registration figures reaching 36,811.

Among the important actions taken by the House of Delegates were enlargement of the Board of Trustees from 11 to 15 members to "improve communications between the Board and the Association," and limitation of the term of office of elected Board members to three years and of the number of terms to three, changes "consistent with the increase in membership of the Association and with the increase of the size of the House of Delegates."

The major change regarding AMA Sections and Scientific Program was the House decision that all section officers should be elected by members of the section and that no officers be appointed by the AMA Board of Trustees. Another change was that nomination of the AMA representatives to serve on the medical specialty certifying board shall be made by the Committee of the Council of Scientific Assembly of the appropriate section and that the nominations shall be submitted to the Board of Trustees. It is now required that a member of a section wishing to change to another section because of a change in his specialty shall so inform AMA Headquarters by written notice at least 60 days in advance of the Annual Meeting. The House also directed the Board of Trustees to implement as soon as possible its





Dr. Edward R. Annis of Miami, President of the American Medical Association, delivers his inaugural address. At ceremonies held at the 112th Annual Meeting in Atlantic City on June 18, 1963, Dr. Annis became the 117th president of that organization and the second member of the Florida Medical Association ever to be elected to Medicine's highest office.

recommendation that a national forum be sponsored by the AMA in which representatives of national medical specialty societies and the Academy of General Practice will participate.

Regarding compensation of house officers, the House recommended that "the AMA record itself as opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage." In another action, the House approved a revision of the Essentials of an Approved Internship which deletes the requirement for any stated proportion of foreign medical graduates and graduates of American and Canadian medical schools as an essential feature of any internship program.

The announcement of the AMA Education and Research Foundation that it will establish and operate a new Institute for Biomedical Research met with the approval of the House. The Institute will be dedicated to intensive and fundamental study of life processes particularly as related to intracellular mechanisms and should be functioning by early 1965.

The House approved establishment of an AMA physicians' pension plan under the provisions of the Self-Employed Individuals' Retirement Act of 1962. The plan will be open to all AMA members and their employees who can qualify under the Act, Public Law 87-792 (Keogh Law), and should be operative in time for physicians to be able to participate this year.

Any public pronouncement regarding the relationship of tobacco and disease was deferred by the House pending the availability of more information. The House declared that extensive research is still necessary for the complete answers on the cause and effect of many toxins, including tobacco. Other actions disapproved the use of federal funds for staffing new community mental health centers, opposed the student loan provisions of the Health Professions Educational Assistance Act of 1963, recommended that local medical societies in the vicinity of medical schools assume the responsibility of establishing and maintaining clear lines of communication with medical students, and urged all state and county medical societies to adopt and activate all phases of "Operation Hometown."

The House commended the American Farm Bureau for its vigorous leadership in opposing unwarranted government interference and regulation. It adopted the recommendations of the Committee to Study the Joint Commission on the Accreditation of Hospitals and suggested that the committee's report be distributed to constituent and component societies and hospital chiefs of staff. In addition, the House urged the widest dissemination to AMA members of a report on The Use of Narcotic Drugs in Medical Practice and the Medical Management of Narcotic Addicts and also recommended that all AMA members and affiliates give strong support to the national tuberculin testing campaign proposed by the American School Health Association.

Respectfully submitted,
Jere W. Annis, M.D.
Burns A. Dobbins Jr., M.D.
Francis T. Holland, M.D.
Meredith Mallory, M.D.
Reuben B. Chrisman Jr., M.D., Chairman

News

The 13th Annual Postgraduate Obstetric-Pediatric Seminar begins August 22 and continues for three days at the Daytona Riviera Motel, Daytona Beach. Dr. James M. Ingram of Tampa, chairman of the Committee on Maternal Welfare of the Florida Medical Association, will serve as moderator for sessions on the opening day, and Dr. Carroll M. Crouch of Daytona Beach, president of the Volusia County Medical Society, will deliver the address of welcome. The program each day begins with a buffet breakfast at 7:15 a.m.

Dr. Joseph A. Shelley of St. Augustine has been chosen to serve as mayor of the city. He recently was elected to a four year term on the City Commission.

Dr. Frank L. Fort of Jacksonville, one of the first orthopedic surgeons to practice in Florida, has been appointed medical director of the Florida Crippled Children's Commission which he was instrumental in creating.

Dr. Edward W. D. Norton of Miami, Professor and Chairman of the Department of Ophthalmology at the University of Miami School of Medicine, has been appointed Chairman of the Visual Sciences Study Section of the National Institutes of Health. His appointment which became effective July 1 will be for a period of four years.

The Second Annual Physicians' Respiratory Diseases Seminar has been scheduled for September 14-15 at the Duval Medical Center in Jacksonville.

The annual course in postgraduate gastroenterology of the American College of Gastroenterology will be given at the Shoreham Hotel in Washington, D.C., on October 24-26.

Dr. Ralph W. Jack of Miami represented the Florida Medical Association at the 22nd annual convention of the National Association for Practical Nurse Education and Service held at Miami Beach.

Grants totaling \$228,414 from the U. S. Public Health Service for continuation of research on a blood disease and investigation of new kinds of tranquilizing drugs have been presented to the University of Florida College of Medicine.

The Fifth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine has been scheduled for Thursday and Friday, December 5-6, at the Grady Memorial Hospital in Atlanta.

The Postgraduate Seminar of the Duval County Medical Society has been announced for September 21-22 at the auditorium of the Duval Medical Center in Jacksonville. Some of the principal speakers include Drs. Walter Dameshek, hematology; Howard Harbing, neuropsychiatry; Eddie Palmer, gastroenterology, and Frank Lock, obstetrics-gynecology.

New Members

The following doctors have joined the State Association through their respective county medical societies.

Active

Arzaga, John L., Orlando
Bercaw, Peter, Fort Myers
Carbonara, Francis J., Fort Pierce
Gordon, Herschel W., Bradenton
Gore, Tom W., Fort Myers
Hampton, John B., Tampa
Heffner, George P., Tavernier
Knowles, John L., Bradenton
Krueger, John J., Fort Myers
Marsteller, Daryl H., Jensen Beach
Ruffolo, Eugene H., Tampa
Sears, Warren W., Pensacola
Sellyei, Louis F., Jr., Maitland
Varker, Carolyn B., Milton
Wargo, J. Donald, Boca Raton
White, Robert C., Bradenton

Associate

Carswell, Paul Jr., Cocoa Beach Cohen, Raymond, South Miami David, Noble J., Coral Gables Dexter, Morris W., Clearwater Freeman, Alfred, Miami Furey, Nicholson W., Pass-A-Grille Gersh, Herbert, Coral Gables Goldstein, Burton J., Miami Grinaker, Arne J., St. Petersburg Hagan, Andrew D., Clearwater Howie, Donald L., St. Petersburg Kaplan, Arnold A., Miami Keyes, Macey H., Coral Gables Kimball. Sanford G., Miami Kleinfeld, George, Miami Lane, Paul J., Miami Moses, Robert J., Hialeah Newquist, Melvin N., Clearwater Oard, Harry C., St. Petersburg Pavilack, Sidney, Miami Shores Rogers, Arvey I., Coral Gables Salzman, Robert T., Miami Shapiro, Jerome B., Coral Gables Sinclair, S. Robert, Miami Beach Sussman, Howard F., Miami Beach Waldner, Charles E., Jr., Belle Glade Wilson, S. Russell, Jr., Alachua Wolff, Theodore M., Miami

Sustained high-level protection in peptic ulcer



all day



all night



with b.i.d. dosage

PRO-BANTHĪNE P.A.

Brand of PROPANTHELINE Bromide Prolonged-Acting Tablets—30 mg.

Pro-Banthīne P.A. provides the full anticholinergic benefit of Pro-Banthīne® plus the greater convenience and more consistent therapeutic effect of a long-acting dosage form.

Asher¹ has summarized the advantages of prolongedaction dosage forms: "First, they should be of great value in the suppression of night acid secretion in the ulcer patient. Also, in the ulcer patient, with high acid secretion during the day these drugs should be of help when used with regular doses of shorter-acting anticholinergic agents. A third application is in the chronic treatment of certain patients whose tendency to recurrent ulcer has been established."

Pro-Banthīne P.A. offers consistent, sustained anticholinergic effects for more consistent suppression of acid secretion and motility on simple twice or thrice daily dosage in most patients.

G.D. SEARLE & CO.

CHICAGO 80, ILLINOIS
Research in the Service of Medicine

Suggested Adult Dosage:

One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of Pro-Banthīne P.A. or standard Pro-Banthīne to meet individual requirements.

Pro-Banthīne P.A.

is supplied as capsule-shaped, peach-colored tablets of 30 mg. each.

Contraindications:

Glaucoma; severe cardiac disease.

Possible Side Actions:

Xerostomia, mydriasis and, occasionally, hesitancy in urination. Theoretically, a curare-like action may occur.

^{1.} Asher, L. M.: The Choice of Anticholinergic Drugs in the Treatment of Functional Digestive Diseases, Amer. J. Dig. Dis. 4:260-275 (April) 1959.

Deaths

Faver, Robert Marshall, Miami, born in Franklin, Ga., on April 8, 1886; Emory University School of Medicine, 1915; interned at Duval County Hospital, Jacksonville, and Memphis Eye, Ear, Nose and Throat Hospital, also serving a residency at the latter institution; practiced in Newnan, Ga., and Lake Geneva, Fla., before locating permanently in Miami where he had practiced his specialty of ophthalmology and otolaryngology since 1931; held membership in the American Medical Association; died May 19, aged 77.

Killinger, Raymond Robert Sr., Jacksonville: born in Rural Retreat, Va., on April 10, 1891: Yale University Medical School, New Haven, Conn., 1919; served an internship at New Haven General Hospital and a residency at Roper Hospital, Charleston, S. C.; Army Medical Corps Reserve, 1919-1936, and graduate school Aviation Medicine, Randolph Field, Texas: engaged in the general practice of medicine and surgery in Rocky Mount, N. C., for two years and Jacksonville for 37 years; was Duval County Medical Examiner from 1928 to 1943, Civil Aeronautics Association examiner for 20 years, and local representative of the Federal Aviation Agency; was a member and past president of the Duval County Medical Society and of the Florida Academy of General Practice, and a member of the American Medical Association, Southern Medical Association, American Academy of General Practice, Aero Medical Association and Air Medics (Texas); died March 24 of a heart attack while fossil hunting near St. Marys, Ga., aged 71.

Kumm, Frederick Fayne, St. Petersburg; born in Madison, Minn., on Nov. 25, 1897; University

PHYSICIAN WANTED

Immediate opening. School City of Gary, Indiana is seeking a physician to administer the health program for 47,000 pupils in 42 schools with 2,600 employees. Will direct 23 nurses, a supervisor, a dentist, part-time physicians and secretarial staff. Insurance and sick leave benefits. Regular office hours. Planned retirement and security. Starting salary \$18,000. For application write to: Dr. Thaddeus P. Kawalek, Asst. Supt.-Personnel, 620 East 10th Place, Gary, Indiana.

of Minnesota Medical School, Minneapolis, 1924; engaged in research in physiology the following year and subsequently taught physiology at Tulane University School of Medicine, New Orleans, and then practiced general medicine for a short time in St. Petersburg; was appointed Assistant Superintendent of State Tuberculosis Sanitorium at Minneapolis in 1929 and later served as Superintendent of the County Tuberculosis Sanitorium at Wadena, Minn.; served from 1933 to 1936 as a captain in the Medical Reserve Corps on active duty with the Civilian Conservation Corps; located permanently in St. Petersburg in 1936; served as City Health Officer and City Physician from 1936 to 1957 and as Director of Public Welfare from 1936 to 1955; continued the private practice of general medicine until ill health forced his retirement in 1961; died March 2, aged 65.

Meleney, Frank Lamont, Miami; born in Somerville, Mass., on Sept. 25, 1889; Columbia University College of Physicians and Surgeons, New York City, 1916; served an internship at Presbyterian Hospital, New York City, from 1916 to 1918; served as a first lieutenant in the United States Army during 1918 and 1919; engaged in the practice of general surgery in New York City from 1919 to 1955 and in Miami since 1955; made many contributions to medical literature and was a lecturer in surgery at the University of Miami School of Medicine; held membership in the American Medical Association, New York Academy of Medicine, American Surgical Association, International Surgical Society, American Geriatric Society, Southern Medical Association, Southeastern Surgical Congress, Society of Clinical Surgery, Halsted Surgical Society and Allen Whipple Surgical Society; was a diplomate of the American Board of Surgery (Founders Group); was a fellow of the American College of Surgeons and an honorary fellow of the International College of Surgeons, Western Surgical Society and Detroit Surgical Society: died March 7, aged 73.

Parr, Grace Whitford, Clearwater: born Grace Lois Ruarc on Feb. 28, 1883, in Chicago; Hahnemann Medical College and Hospital, Chicago, 1904; settled in Ozona in 1909 with her husband, the late Dr. H. E. Whitford, with whom she practiced medicine for many years until his death; retired from active practice in 1946 and married Mr. Henry Parr, who died several years ago; was one of the first staff members of Morton Plant Hospital, Clearwater, and was active in its advancement through the years; served 14 years on the District Four Welfare Board of Pinellas County and was active in the Civil Defense program as well as in numerous other local and state organizations; died January 29, aged 79.

Phillips, Neal John, Tampa; born in Chicago on May 6, 1904; Washington University School of Medicine, St. Louis, Mo., 1929; practiced medicine in Chicago and Kingman, Ariz., before entering military service in 1940; served in the Army Medical Corps throughout World War II in Greenland, Iceland and the China-Burma-India Theatre; upon discharge in 1946, established a practice in dermatology and later part time general medicine in Tampa; held membership in the American Medical Association, American Academy of Dermatology, Southeastern Dermatology; died in Mexico on March 16 following a heart attack, aged 58.

Silverstone, Eugene Henry, Coral Gables; born in Seattle, Wash., in 1905; University of Illinois College of Medicine, Chicago, 1931; was a retired colonel with the United States Air Force, having served 28 years; came to Miami in 1949 from Chicago, and had been commanding officer of the Air Force Reserve Medical Flight in Miami; had been in private practice only six years and was chief of the orthopedic service at Coral Gables Veterans Hospital at the time of his death; held membership in the American Medical Association and was a fellow of the American College of Surgeons; died suddenly after a heart attack on April 17, aged 58.

Smith, Charles Kirby, Homestead; born in Holly Hill, S. C., on Jan. 4, 1894; Medical College of South Carolina, Charleston, S. C., 1923; served an internship at New York Lying In Hospital, New York City, and a residency in Jackson Memorial Hospital, Miami; was a veteran of World War I; practiced obstetrics and gynecology for 31 years in Miami until multiple sclerosis forced his retirement in 1963; died April 29, aged 69.

Meetings

August

Thirteenth Annual Postgraduate Obstetric-Pediatric Seminar, August 22-24, Daytona Riviera Motel, Daytona Beach

September

Second Annual Physicians' Respiratory Diseases Seminar, September 14-15, Duval Medical Center, Jacksonville Florida Psychiatric Society, Fall Meeting, September 20-22, Palm Beach Towers, Palm Beach

Postgraduate Seminar of the Duval County Medical Society, September 21-22, Auditorium, Duval Medical Center, Jacksonville

October

Florida Academy of General Practice, Fourteenth Annual Scientific Assembly, October 10-13, Civic Center, Lakeland

 Postgraduate Symposium in Orthopaedics, Trauma, Minor Surgery and Office Orthopaedics, October 17-19, Auditorium, Mound Park Hospital, and Clinic, American Legion Hospital for Crippled Children, St. Petersburg
 Florida Society of Anesthesiologists, October 19-20, Sheraton-Tampa Motor Inn, Tampa

Florida Orthopedic Society, Fall Meeting, October 25-27, Port Paradise Hotel, Crystal River

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, hed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA

Patronize Your
Independent X-ray Dealer

He'll be around when you need him

BOB WAGNER X-RAY

P. O. Box 8161 Jax 11, Florida RA 4-3434.

153

CLASSIFIED

Advertising rates for this column are \$5.00 per insertion for ads of 25 words of less. Add 20c for each additional word.

FOR RENT: Complete office. Ready to move into in the Doctors Building. \$110. per month including air-conditioning, heat, hot water and janitor service. Downtown location, abundance of free parking for patients. Contact S. J. Wilson, M.D., 309 N. E. River Drive. Fort Lauderdale, Fla.

WANTED: General Practitioner, Internist. Pediatrician, to join surgeon in new clinic. Exciting growth enterprise in finest Cape Canaveral location. Arrangements open. Write 69-484, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Excellent general practice and equipment, Miami Beach area, established 30 years same location. Contact: Medical Business Consultants, 1101 N.E. 79th Street. Miami. PL 9-0230.

PEDIATRICIAN WANTED: For association in Hollywood, Fla. Must be Board qualified or certified. For information contact Medical Business Consultants, 1101 N.E. 79th St., Suite 205, Miami, Fla. Telephone PL 9-0230.

WANTED: Pediatrician, ENT. Internist and Dermatologist for new medical building ready Feb. 15. Adjacent to hospital in beautiful location on Gulf of Mexico. Fine practice opportunity. Write 69-510, P.O. Box 2411, Jacksonville, Fla.

MEDICAL OFFICE AVAILABLE: Unusual opportunity for GP or specialist in Miami Beach. Call Jefferson 1-1246 or contact: Dr. Leonard Sakrais, 1500 Bay Rd., M'ami Beach, Florida.

OFFICE FOR RENT: Share waiting and reception area with dentist in an office in a professional building. Parking. Three 10 by 10 rooms plus bathroom. Rent \$160. Share utilities. Write Dr. Steven H. Rose, 1119 South Flagler Dr., West Palm Beach, Fla.

INTERNIST WANTED: To occupy adjoining office and work in cooperation with established internist. Good residential area on East coast. Write 69-536, P.O. Box 2411, Jacksonville, Fla.

OPHTHALMOLOGIST WANTED: For unopposed excellent location East coast. Good cooperation from other physicians. Rent concession until established. Write 69-537, P.O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN WANTED: To work in cooperation with obstetrician in unopposed high grade residential area. Flexible rent arrangement. Write 69-538, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Solidly established Miami Beach general medical practice and equipment. Will introduce and cooperate fully. Leaving practice for psychiatry residency in this area. Write or phone Dr. Greenberg, 350 Washington Ave., Miami Beach. JE 1-7057.

PEDIATRICIAN WANTED: Board eligible, Florida licensed, with view of complete transfer of practice in near future. On West coast in middle-class community near good hospitals and universities. Write 69-528, P.O. Box 2411, Jacksonville, Fla.

OPTICAL DISPENSER: Desires position with eye physician doing or considering dispensing eyewear. Could furnish own equipment and samples if necessary. Would locate anywhere in greater Miami area between Pompano and South Miami. Write or call L. Hilker, 2647 Madison Street, Hollywood, Fla., Wabash 2-3241.

WANTED: Young physician to share office and practice. \$12,000 first year with partnership to follow. Write full particulars first letter. Write 69-540, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER: I will sublet my office in West Palm Beach to a qualified physician. Rent. including use of my equipment, \$175. per month. Write 69-530, P.O. Box 2411, Jacksonville, Fla.

TWO SUITES AVAILABLE: New modern Medical-Dental building, air-conditioned, plumbing-partitioning-parking. Three dentists occupy two suites. Ideal location Fort Lauderdale for General Practitioner and/or specialists. Write 69-533, P.O. Box 2411, Jacksonville, Fla.

OFFICE SPACE FOR RENT: Medical suite, approximately 600 sq. ft. in separate consultation, two treatment and laboratory rooms. Share secretary and reception room. New professional building, excellent furnishings. Suitable for specialty or general practice. Clarence H. Schilt, M.D., 2161 McGregor Bldg., Ft. Myers, Fla.

WANTED: General Practitioner for Clinic-Hospital. Salary open—plus bonus. Write 69-535, P.O. Box 2411, Jacksonville, Fla.

PHYSICIAN WANTED: For full time position in occupational medicine for large Industrial Plant located in Central Florida. This is an interesting and challenging job. Experience in industrial medicine desirable but not mandatory. Florida license required. Applicants should send a resume of their qualifications to: Industrial Relations Department, American Cyanamid Company, Brewster Plant, Bradley, Florida.

AVAILABLE: For \$90 enjoy professional suite of 4 rooms air-conditioned in Medical Arts Building, 503 W. Platt, Tampa. Phone 251-1600.

PRACTICE FOR SALE: Ideal for two well suited E.E.N.T. specialists in thriving community where you are needed. Congenial colleagues will support you. 2,600 sq. ft. of air-conditioned space. Off street parking. Modern equipment and complete instruments for examinations of Ophthalmology and Otolaryngology. Deceased was diplomate of O.L.A.R. and member F.A.C.S. Office established over 30 years. For details write Mrs. J. N. McLane, 1212 N. Palafox St., Pensacola Fla

LAKEFRONT HOME FOR QUICK SALE: (By owner) 4 bedroom, 3 bath, CBS reinforced concrete steel bungalow and garage on Lake McCoy-Lake Placid. Completely furnished, air-conditioned and heat. Beautifully landscaped, fruit trees, double sprinkler system. Terms if desired. Contact John Francis, 1040 S. Federal Highway, Hollywood, Fla. Phone WA 2-0865.

CERTIFIED PHYSIATRIST with some years' experience. Florida license. Will be glad to consider location in Florida. Write 69-539, P.O. Box 2411, Jacksonville, Fla.

INVESTMENT OPPORTUNITY: Eight newly completed, fully occupied, two bedroom apartment units, air-conditioned, in fast growing Cape Canaveral, Florida. 20 per cent return on \$75,000 investment. Write Atlantic Homes, 1611 San Marco Blvd., Jacksonville, Fla.

FOR SALE: Outstanding ophthalmological practice of 40 years' standing with full examining and surgical equipment, very complete in every detail. Five large rooms, medical building in metropolitan area. Practice available immediately due to death. Contact office of Dr. S. B. Forbes, 409 Citizens Building. Tampa 2, Fla.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 3. This service is for the use of physicians seeking locations, as well as physicians seeking associates.



ISOCLOR TIMESULE

CLOR TIMESULE CONTAINS:

niramine maleate 10 mg. edrine HCL 65 mg. cial form providing prolonged ic effect



Schematic drawing of Timesule cell owing dialysis ugh permeable coating.



A NEW COMPREHENSIVE RELIEF

- Relief usually starts in minutes—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
- Relief usually lasts up to 12 hours with a single oral dose
- Gives both upper respiratory decongestion and bronchodilatation to relieve chest discomfort
- With minimal drowsiness, CNS or pressor stimulation

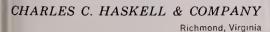
MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

DOSE: Adults: One Timesule every 12 hours, or as directed.

warning: Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

Send for Samples and Literature





Books Received

The following books have been received. Those which appear to be of particular interest will be reviewed as space permits.

Office Procedures. By Paul Williamson, M.D. Ed. 2. Pp. 448. Price \$13,50. Philadelphia. W. B. Saunders Company, 1962.

Synopsis of Genitourinary Disease. By Austin I. Dodson, Jr. M.D., and J. Edward Hill, M.D. Ed. 7. Pp. 384. Illus, 123. Price \$7.75. St. Louis, The C. V. Mosby Company, 1962.

Synopsis of Roentgen Signs. By Isadore Meschan, M.A., M.D., with the assistance of R. M. F. Farrer-Meschan, M.B., M.S. (Melbourne, Australia), M.D. Pp. 436. Illus. 1,488 on 465 figs. Price \$11.00. Philadelphia, W. B. Saunders Company, 1962.

Resistance of Bacteria to the Penicillins. Ciba Foundation Study Group No. 13. Edited by A.V.S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A. Pp. 125. Illus. 14. Price \$2.95. Boston, Little. Brown and Company, 1962.

Transplantation. Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.E.B., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A. Pp 426. Illus, 71. Price \$12.00. Boston, Little, Brown and Company, 1962.

Endocrine and Metabolic Aspects of Gynecology. By Joseph Rogers, M.D. Pp. 189. Illustrated. Price 88.00. Philadelphia, W. B. Saunders Company, 1963.

Surgery. By Richard Warren, M.D. In Collaboration with Members of the Department of Surgery of the Har-

vard Medical School. Pp. 1397. Illustrated. Price \$19.50. Philadelphia, W. B. Saunders Company, 1963.

Gastroenterology. By Henry L. Bockus, M.D. Ed. 2. Vol. I. Pp. 958. Illustrated. Price \$25.00. Philadelphia, W. B. Saunders Company, 1963.

Medical Laboratory Technology. By Matthew J. Lynch, M.D. (N.U.I), M.R.C.P. (Lond.), F.C.A.P., Stanley S. Raphael, M.B., B.S., (Lond.), Leslie D. Moller, L.C.S.L.T., F.I.M.L.T., Peter D. Spare, F.I.M.L.T., Peter Hills, L.C.S.L.T., F.R.M.S., and Martin J. H. Inwood, L.C.S.L.T., F.I.M.L.T. Pp. 735. Illustrated. Price \$12.00. Philadelphia, W. B. Saunders Company, 1963.

Current Diagnosis and Treatment. By Henry Brainerd, M.D., Sheldon Margen, M.D., and Milton J. Chatton, M.D. Pp. 843. Price \$9.50. Los Altos, Calif., Lange Medical Publications, 1963.

Synopsis of Pediatrics. By James G. Hughes, B.A., M.D. Pp. 1031. Illustrated. Price \$9.85. St. Louis, The C. V. Mosby Company, 1963.

Pye's Surgical Handicraft. Edited by Hamilton Bailey, F.R.C.S. (Eng.), F.A.C.S., F.R.S. (Edin.). Ed. 18, Vol. II. Pp. 424. Price \$8.50. Baltimore, The Williams and Wilkins Company, 1962.

Physiology of the Circulation in Human Limbs in Health and Disease. By John T. Shepherd, M.D., M.Ch., D.Sc. Pp. 416. Illus. 179. Price \$12.00. Philadelphia, W. B. Saunders Company, 1963.

Evaluation of Thyroid and Parathyroid Functions. Edited by F. William Sunderman, M.D., Ph.D., Sc.D., and F. William Sunderman, Jr., M.D. Pp. 292. Price \$12.50. Philadelphia. J. B. Lippincott Company, 1963.

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis, fat accumulation, weight gain; thus appear to aggravate obesity in diabetics¹⁻⁵...serum "insulin" levels are often elevated in obese diabetics^{2,3,6}...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.^{1,3,7-9}

most effective in the obese diabetic

DB DB DB DB timed-disintegration capsules 50 mg

BRAND OF PHENFORMIN HCI



Current Therapy 1963. Latest Approved Methods of Treatment for the Practicing Physician. Edited by Howard F. Conn, M.D. Pp. 775. Price \$12.50. Philadelphia, W. B. Saunders Company, 1963.

Protein Metabolism. Influence of Growth Hormone, Anabolic Steroids and Nutrition in Health and Disease. An International Symposium, Leyden, 25th-29th June, 1962. Sponsored by Ciba. Chairman A. Querido, Leyden. Edited by F. Gross, Basle. Pp. 521. Illus. 159. Berlin-Göttingen-Heidelberg, Springer Verlag, 1962.

The Management of the Anxious Patient. By Ainslie Meares, M.D., B.Agr.Sc., D.P.M. Pp. 493. Price \$9.00. Philadelphia, W. B. Saunders Company, 1963.

This Air We Breathe. By Clarence A. Mills, M.D., Ph.D., LL.D.(Hon.). Pp. 172. Price \$4.00. Boston, The Christopher Publishing House, 1962.

Thoracic Surgery. Surgery in World War II. Medical Department, United States Army. Prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. Editor in Chief, Colonel John Boyd Coates, Jr., MC, USA; editor for Thoracic Surgery, Frank B. Berry, M.D. Pp. 394. Illustrated. Washington, D.C., Office of the Surgeon General, Department of the Army, 1963.

Vascular Surgery. By John B. Kinmonth, M.B., M.S. (Lond.) F.R.C.S. (Eng.), Charles G. Rob, M.C., M.A., M. Chir. (Camb.), F.R.C.S. (Eng.), and Fiorindo A. Simeone, A.B., Sc.M., M.D., Sc.D. (Hon.). Pp. 501. Illustrated. Price \$19.00. Baltimore, The Williams and Wilkins Company, 1963.

Clinical Metabolism of Body Water and Electrolytes. By John H. Bland, M.D. Pp. 623. Illustrated. Price \$16.50. Philadelphia, W. B. Saunders Company, 1963.

Handbook of Pediatrics. By Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. Ed. 5. Pp. 602. Price \$4.00. Los Altos, Calif., Lange Medical Publications, 1963.

Electrocardiography. By Michael Bernreiter, M.D., F.A.C.P. Ed. 2. Pp. 202. Illustrated. Price \$7.50. Philadelphia, J. B. Lippincott Company, 1963.

Counseling in Medical Genetics. By Sheldon C. Reed, Ph.D. Ed. 2. Pp. 278. Price \$5.50. Philadelphia, W. B. Saunders Company, 1963.

Intestinal Biopsy. Ciba Foundation Study Group No. 14. Edited by G.E.W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A. Pp. 120. Illus. 53. Price \$2.95. Boston, Little, Brown and Company, 1962.

Bilharziasis. Ciba Foundation Symposium. Edited by G.E.W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Pp. 433. Illus. 46. Price \$11.50. Boston, Little, Brown and Company, 1962.

Birth Defects. Edited by Morris Fishbein, M.D. Pp. 335. Illustrated. Price \$5.00. Philadelphia, J. B. Lippincott Company, 1963.

Fluid and Electrolytes in Practice. By Harry Statland, M.D. Ed. 3. Pp. 329. Price \$8.50. Philadelphia, J. B. Lippincott Company, 1963.

Handbook of Pediatric Medical Emergencies. By Adolph G. DeSanctis, M.D., and Charles Varga, M.D., and Contributors. Ed. 3. Pp. 457. Illus. 85. Price \$12.75. St. Louis, The C. V. Mosby Company, 1963.



DBI and DBI-TD (phenformin HCI),

administered to ketoacidosis-resistant diabetics requiring hypoglycemic therapy: A. act to reduce high blood sugar without increasing fat synthesis or weight gain as insulin and sulfonylureas tend to do. B. do not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal insulin levels. C. favor reduction of weight towards normal.

Insulin is still the essential hypoglycemic agent for the ketoacidosisprone diabetic. However, in the ketoacidosis-resistant obese diabetic phenformin appears to be the hypoglycemic of choice to help avoid weight gain or reduce adiposity, a factor tending to make control more difficult and to increase the likelihood of complications.

Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:737, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A. June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

U. S. VITAMIN & PHARMACEUTICAL CORP.

800 SECOND AVENUE, NEW YORK 17, N.Y.

Question:

"What is a tranquilaxant?"

Answer:

"A drug that is both a tranquilizer and a muscle relaxant."

TRANCOPAL chlormezanone is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone/Winthrop) "is effective in the symptomatic treatment of anxiety." Its tranquilizing properties are similar to those of other mild tranquilizers. Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties² of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of TRANCOPAL (chlor-mezanone/Winthrop)—a true "tranquilaxant"—is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCO-PAL (chlormezanone/Winthrop), such as occa-

sional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets[®] (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

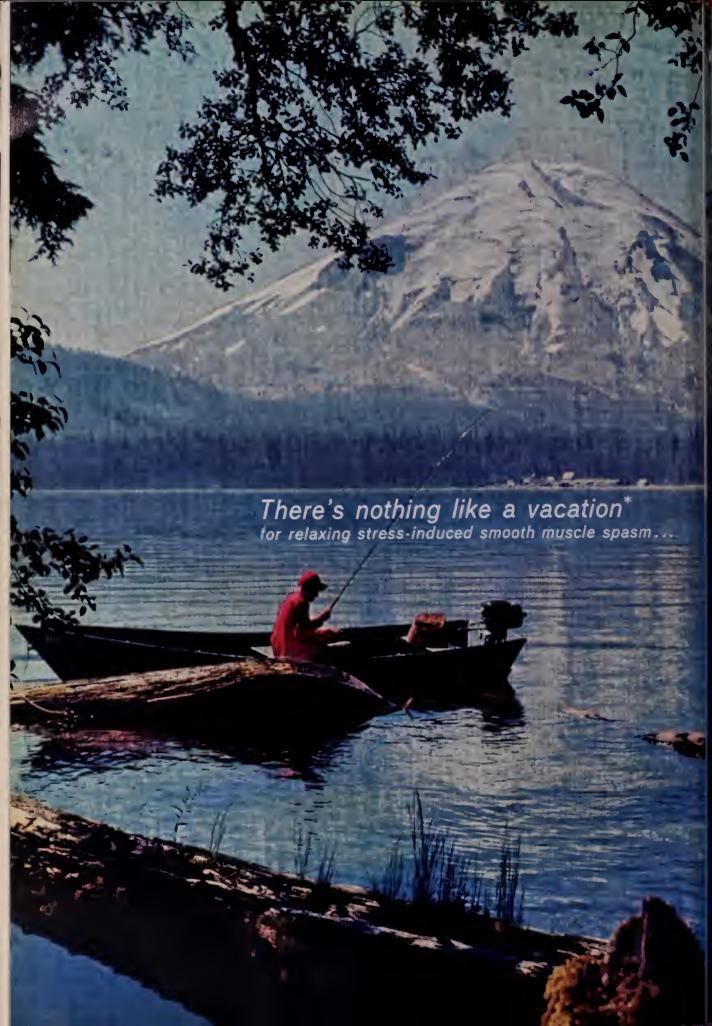
References: 1. A.M.A. Council on Drugs: J.A.M.A. <u>183</u>:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. <u>2</u>:1 (Jan.) 1960.



out impairment of normal muscle strength or neuromuscular function. Side effects, such as lightheadedness, dizziness, drowsiness, and nausea, may occur rarely, but usually disappear when dosage is reduced. Hypersensitivity reactions have been reported infrequently. Contraindicated in patients hypersensitive to the drug.

Average adult dose	
ROBAXIN®	ROBAXIN®-750
(methocarbamol, 500 mg./tab.)	(methocarbamol, 750 mg./tab.)
Initially3 tablets q.i.d.	2 tablets q.i.d.
Maintenance 2 tablets q.i.d.	1 tablet q.4 h.
	or 2 tablets t.i.d.

A. H. ROBINS CO., INC., Richmond 20, Virginia



...nothing, that is, except the sedative-antispasmodic action of

Donnatal



In each Tablet, Capsule	In each
or 5 cc. Elixir	Extentab
0.1037 mg, hyoscyamine sulfate	0.3111 mg.
0.0194 mgatropine sulfate	.0.0582 mg.
0.0065 mghyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.) phenobarbital (¾ gr.)) 48.6 mg.
(Warning: May be habit forming)	

Prescribed by more physicians than any other antispasmodic—well over 5 billion doses!

A. H. ROBINS CO., INC., Richmond 20, Virginia

Outstanding effectiveness in clinical usage—plus freedom from the risk of serious side effects—are the compelling reasons why DONNATAL has maintained its pre-eminent position as a smooth muscle relaxant through the years.

Over 5 billion doses have been administered since its introduction...impressive evidence of professional confidence in the clinically reported benefits provided by DONNATAL:

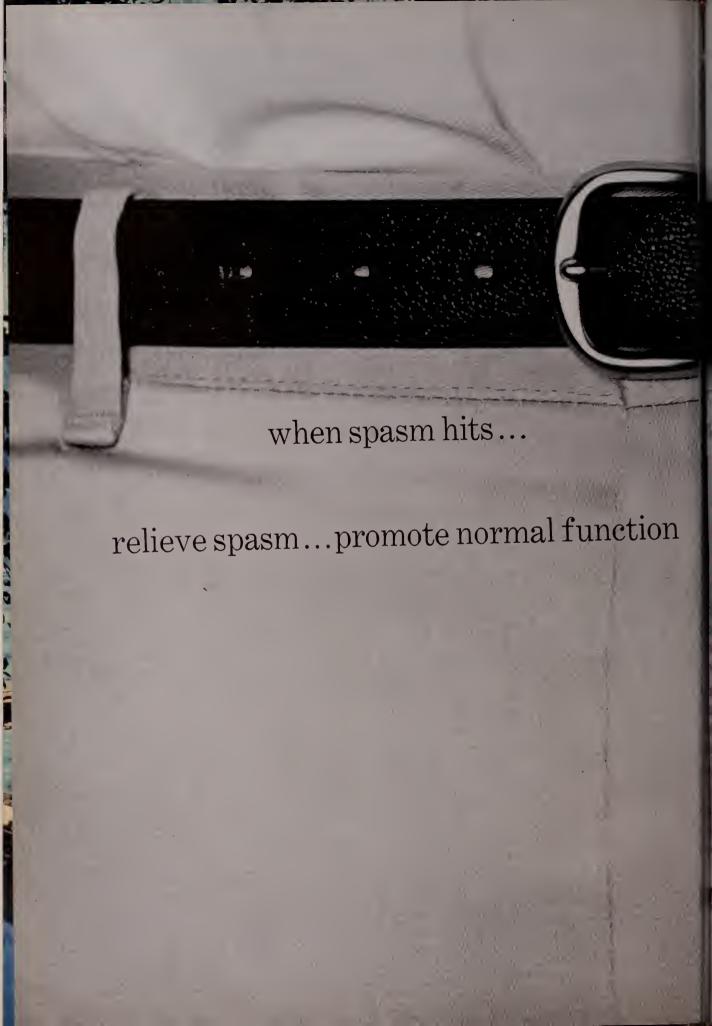
- excellent results in a wide range of visceral disorders 1.6
- well tolerated¹-6
- convenient dosage forms^{1,3}
- uniform composition^{1,3}
- stability 1,3
- economy^{1,3}

DONNATAL is indicated in recurring, persistent or chronic visceral spasm, as in: peptic ulcer, pylorospasm, irritable stomach and colon, nervous indigestion, dysmenorrhea, nausea of pregnancy, motion sickness, nocturnal enuresis, mucous colitis and diarrhea.

No serious toxic reactions are to be anticipated. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage, but promptly disappear with reduction in dosage.

Donnatal is contraindicated in acute glaucoma, advanced hepatic or renal disease, and known or suspected idiosyncrasy to any of its components. Patients with incipient glaucoma or urinary bladder neck obstruction must be treated with care, as with any preparation containing a parasympathetic depressant.

REFERENCES: 1. Barden, F.W., Hill, P.S., Mahaney, W.F., and Cuneo, K.J.: J. Maine M.A. 45:11, 1954. 2. Chaput, Y., and Baillargeon, J.: L'Union med. du Can. 86:205, 1957. 3. Hock, C.W.: Clin. Med. 8:1932, 1961. 4. Kilstein, R.I.: Rev. Gastroenterol. 14:171, 1947. 5. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 6. Wharton, G.K., Balfour, D.C., Jr., and Osmon, K.L.: Postgrad. Med. 21:406, 1957.





 $w PATHILON ^*SEQUELS ^*with Phenobarbital$

TRIDIHEXETHYL CHLORIDE Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride...75 mg.; Phenobarbital...45 mg.

mulated for controlled release of the active redients, for sustained anticholinergic proion against spasm and pain in the G.I. tract. vell as sustained phenobarbital action.

ninates the necessity for numerous doses; tens out "peaks and valleys" in drug blood els that can minimize effectiveness; and reses protective medication through the night. ective in organic and functional disorders the gastrointestinal tract (duodenal ulcer, estinal colic, ileitis, esophageal spasm, estinal spastic colon, alcohol-induced G.I. sets, gastric hypermotility) and anxiety neurosis with G.I. symptoms. Should be used as an adjunct to other measures. Side Effects due to tridihexethyl chloride: dry mouth, blurring of vision, constipation. Contraindications: urinary bladder neck obstruction: glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention. Supply: Bottles of 30 and 500.

Also available: PATHILON SEQUELS (without phenobarbital) Tridihexethyl chloride, 75 mg. Bottles of 30 and 500.



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, N.Y.



Relieves Anxiety and Anxious Depression

The outstanding effectiveness and record of safety with which 'Miltown' (meprobamate) relieves anxiety and anxious depression has been clinically authenticated time and again during the past eight years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more than any other tranquilizer in the world.

Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or

alcohol addiction. Withdraw gradually afte prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d Supplied: 400 mg. scored tablets, 200 mg sugar-coated tablets; bottles of 50.

the original meprobamate Miltown

WALLACE LABORATORIES / Cranbury, N.J.

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE

4539 Beach Blvd. Telephone FL 9-2191

ORLANDO

1511 Sligh Blvd. Telephone GA 5-3537

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Avenue, N. E. St. Petersburg, Florida Phone 862-6903



314B John Ringling Blvd Sarasota, Florida Phone 388-1604

> Box 514 Miami 62, Florida Phone 945-4055

Affiliates of Black & Skaggs Associates Battle Creek, Michigan

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem.

KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition



Parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart an request.



hatham CHATHAM PHARMACEUTICALS, INC.

Newark 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontaria

WILLIAM B. TERHUNE, M.D.

THE SILVER HILL FOUNDATION

New Canaan

Connecticut

Announces:

Appointment available for Senior Associate. Board Certified in Psychiatry to join our Group in the active practice of pyschiatry. The Silver Hill Foundation is a psychotherapeutic unit for the treatment of the functional nervous disorders. The setting is that of a comfortable country home where a limited number of patients are under intensive, re-educational treatment for a period of several weeks.

Ideal work conditions, scientific freedom and guaranteed income. Only well qualified physician, capable of advancement should APPLY TO: Dr. William B. Terhune, Medical Director, New Canaan, Connecticut.

Associates: Dr. Marvin G. Pearce

Dr. Robert B. Hiden Dr. William M. White Dr. William D. Wheat Dr. Warren A. Mann Dr. Morgan F. Moore

Westbrook Psychiatric Hospital, Inc.

(formerly Westbrook Sanatorium, Inc.)
FOUNDED 1911

Richmond, Virginia

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

REX BLANKINSHIP, M.D. President

THOMAS F. COATES, JR., M.D.
Assistant Medical Director

JOHN R. SAUNDERS, M.D. Medical Director

J. McDERMOTT BARNES, M.D.
Associate

R. H. CRYTZER Administrator

BROCHURE OF LITERATURE AND VIEWS SENT ON REQUEST write to:

WESTBROOK PSYCHIATRIC HOSPITAL, INC. P. O. Box 1514, Richmond 27, Virginia Telephone 359-5701

FIRST EXPLOSION-PROOF

Surgical Headlight

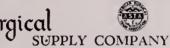
The only headlight approved by Underwriters' Laboratories for use with explosive gases. Completely self-contained—no trailing cords. Rechargeable batteries worn by surgeon on belt. Sterilizable. Brilliant, color-corrected, focusing light. Separate recharger unit.

WELCH ALLYN (R)

WELCH "ALLYN







Telephone: ELgin 5-8391 1050 West Adams Street Jacksonville 3, Florida





2 Years-No Treatment

THEY DO NOT RECOVER— SPONTANEOUSLY

They need combination treatment; multiple clinical evaluations are proving this.

Add to your routine medical or surgical management ONE OF THE PHYSICAL AGENTS especially designed for your office or home use. For pain, edema and as a decongestant, FORTIFY muscular relaxants with ultrasonic energy.

For facial and small muscular rehabilitation, add the specially designed Zeigler Model Y-4.





Model Y-4 For Office or Home Use





U. S. Model 108

ZEIGLER OF FLORIDA, INC.

495 Biltmore Way, Coral Gables 34, Fla., Phone 444-5283

APPALACHIAN HALL

ASHEVILLE

Established 1916

NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or ensuite

Wm. Ray Griffin Jr., M.D. Robert A. Griffin, M.D. Mark A. Griffin Sr., M.D. Mark A. Griffin Jr., M.D.

For rates and further information write Appalachian Hall, Asheville, N. C.

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders and Invalids Alcoholics Treated



5226 Nichol St. Telephone 61-4191

DON SAVAGE Owner and Manager Aged adjudged cases will be accepted on either permanent or temporary basis.

Safety against fire — by Automatic Fire Sprinkling System.

Cyclone fence enclosure for recreation facilities, seventy-five by eighty-five feet.

ACCREDITED
HOSPITAL FOR
NEUROLOGICAL
PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

P. O. Box 10368 Tampa 9, Florida

CONVENTION PRESS

218 W. CHURCH ST. JACKSONVILLE, FLORIDA

QUALITY
BOOK PRINTING
PUBLICATIONS
BROCHURES

W HATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine quality work—and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

HCV CREME

3% Iodochlorhydroxyquin1% Hydrocortisone

Provides ANTIFUNGAL, ANTIBACTE-RIAL, ANTI-INFLAMMATORY AND AN-TIPRURITIC action in dermatitis.

GEVIZOL

Each 5 cc. tspfl or tablet provides 100 mg. Pentylenetetrazol, 50 mg. Nicotinic acid. GEYIZOL is indicated in the treatment of the mentally confused, emotionally unstable, apathetic aged and aging patient. For the patient complaining of dizziness or fogginess. Reactivates the inactivated.

QUALITY SARON ECONOMY
PHARMACAL
CORPORATION

St. Petersburg

Florida



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dusage: 1 or 2 tablets before meals and at bedtime. Individualization required.

Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / Cranbury, N. J.

TUCKER HOSPITAL, INC.

212 West Franklin Street RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological patients. Hospital and out-patient services.

(Organic diseases of the nervous system, psychoneuroses, psychosomatic disorders, mood disturbances, social adjustment problems, involutional reactions and selective psychotic and alcoholic problems.)

Dr. James Asa Shield Dr. George S. Fultz, Jr. Dr. Weir M. Tucker Dr. W. Frederick Young



Out-Patient Clinic and Offices

James A. Becton, M.D.

P. O. Box 2896, Woodlawn Station, Birmingham 6, Ala.

Phone WO 1-1151 and WO 1-1152

Specialized Service

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

48:03

MEDICAN PROPERTY COMPANY

ACCORD STORY VALOR

Professional Protection Exclusively since 1899

MIAMI OFFICE: H. Maurice McHenry, Rep. 149 Narthwest 106th Street, Miami Shares Tel. Plaza 4-2703



compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.



BRAWNER HOSPITAL. INC.

(Established 1910)

2932 South Atlanta Road, Smyrna, Georgia

FOR THE TREATMENT OF PSYCHIATRIC ILLNESSES AND PROBLEMS OF ADDICTION

MODERN FACILITIES

JAS. N. BRAWNER, JR., M.D. Medical Director

ALOYSIUS I. MILLER, M.D. MARK A. GOULD, M.D.

Phone HEmlock 5-4486



P. L. DODGE MEMORIAL HOSPITAL

formerly

MIAMI MEDICAL CENTER

M. G. ISAACSON, M.D. Medical Director and President

1861 N.W. South River Drive Phone 379-1448

A private institution for the treatment of nerous and mental disorders and the problems of
drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including — Psychotherapy, Insulin, & Electroshock,
when indicated. Adequate facilities for recreation and out-door activities.

Information on request
Member NAPPH and American Psychiatric Assn.

The distinctive PREMIERE suite



By Hamilton

Smartly styled and finished entirely in lifetime materials. Wood-grained Formica in gray or cream, satin-finish stainless steel and bright chrome create a contemporary, fully Professional atmosphere — and the Premiere will keep its dignified look for a lifetime. Five essential pieces in the suite; table, instrument cabinet, treatment cabinet, waste receptacle and stool. The table is extra large and has a new contour upholstered top to give patients more comfort and security. Other innovations on the table include adjustable chrome legs for leveling or raising the table. The usual features of Hide-A-Roll, treatment basin and pull-out step are included.

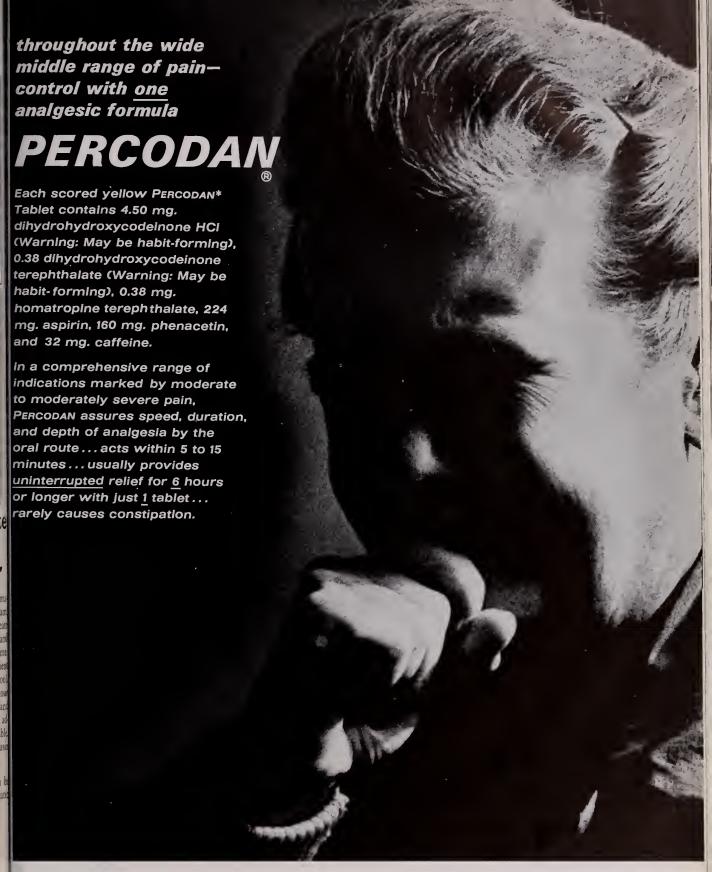
Versatility is the keynote of the Premiere suite. The upper section of the instrument cabinet can be used separately as a wall cabinet and the lower section as a treatment stand. This option allows a greater variety of room arrangement according to personal preference and requirements.

See the new Premiere and other Hamilton suites in wood and steel now.

Anderson Surgical Supply Co.

ESTABLISHED 1916

Phone CHerry 1-9589 1616 N. Orange Ave. Orlando Phone 896-3107 556 9th St. S. St. Petersburg Phone 229-8504 Morgan at Platt Tampa Phone 376-8253 729 S.W. 4th Ave. Gainesville

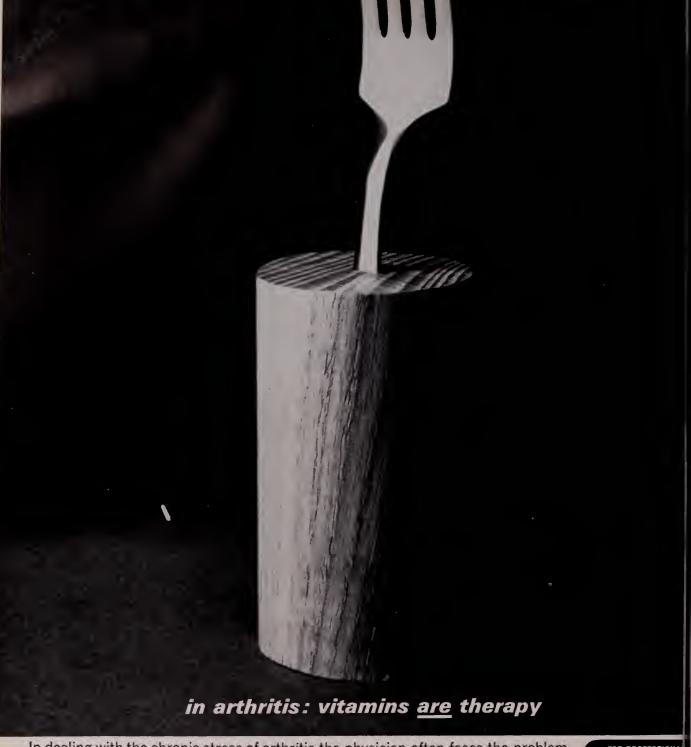


Average Adult Dose—1 tablet every 6 hours. Side Effects and Contraindications—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. Also available: PERCODAN®-DEMI,

containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxy-codeinone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. Literature on request.

ENDO LABORATORIES Richmond Hill 18, New York





In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease.

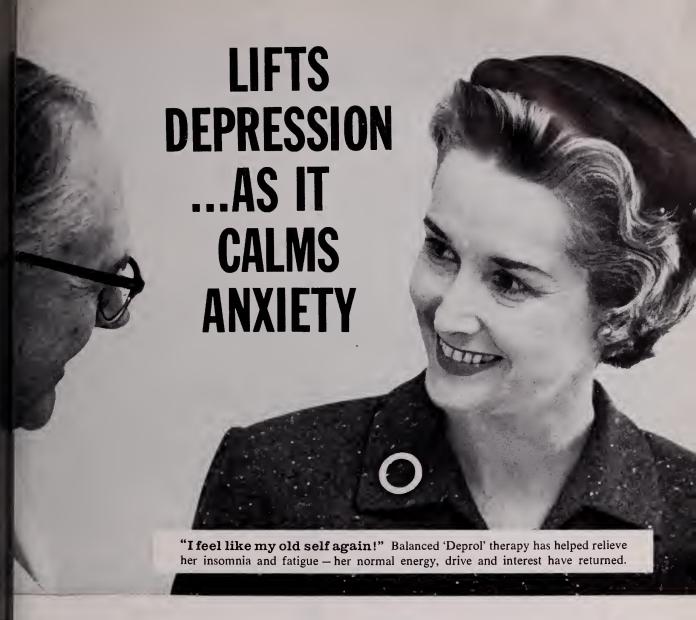
Each capsule contains: Vitamin B₁ (Thiamine Mononitrate)...10 mg. / Vitamin B₂ (Riboflavin)...10 mg. / Niacinamide...
100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B₆ (Pyridoxine HCl)...2 mg. / Vitamin B₁₂ Crystalline...
4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.





LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River,

STRESSCAPS® Stress Formula Vitamins Lederle



Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

'Deprol'

meprobamate 400 mg. + benactyzine 1 mg.

WALLACE LABORATORIES / Cranbury, N.J.



FLORIDA MEDICAL ASSOCIATION

735 Riverside Ave., P. O. Box 2411

Jacksonville 3, Florida

Officers

WARREN W. QUILLIAN, M.D., President	Coral Gables
SAMUEL M. DAY, M.D., President-Elect	
H. PHILLIP HAMPTON, M.D., Vice President	Tampa
EUGENE G. PEEK JR., M.D., Speaker of the House	Ocala
FRANKLIN J. EVANS, M.D., Vice Speaker	Coral Gables
FLOYD K. HURT, M.D., Secretary-Treasurer	Jacksonville
ROBERT E. ZELLNER, M.D., Immediate Past President	Orlando
W. HAROLD PARHAM, Executive Director	Jacksonville

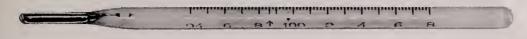
Councils

THOMAS C. KENASTON SR., M.D., Chairman, Council on Allied Professions and Vocations	Cocoa
JERE W. ANNIS, M.D., Chairman, Judicial Council	Lakeland
H. PHILLIP HAMPTON, M.D., Chairman, Council on Legislation and Public Agencies	
BURNS A. DOBBINS JR., M.D., Chairman, Council on Medical Economics	Fort Lauderdale
HUGH A. CARITHERS JR., M.D., Chairman, Council on Medical Education and Hospitals	Jacksonville
CHARLES R. SIAS, M.D., Chairman, Council on Medical Services	
THAD MOSELEY, M.D., Chairman, Scientific Council	Jacksonville
WALTER C. PAYNE SR., M.D., Chairman, Council on Special Activities	Pensacola
EMMET F. FERGUSON JR., M.D., Chairman, Council on Specialty Medicine	Jacksonville
MASON ROMAINE III, M.D., Chairman, Council on Voluntary Health Agencies	Jacksonville

INDEX TO ADVERTISERS

		·	
• Ames Co., Inc.	Third Cover	Physicians Products, Inc	123
• Anderson Surgical Supply Co.		• P. L. Dodge Memorial Hospital	170
• Appa'achian Hall	166	• PM of Florida	163
c Arnar-Stone Laboratories	158	• A. H. Robins Co 123, 158a,	159
e Ba"ast Point Manor		• Roche Laboratories Back Co	ve:
Brawner Hospital, Inc	170	• Sanborn Co.	110
Brown Pharmaceutical Co	119	• Saron Pharmacal Corp.	16
Burroughs Wellcome & Co	120	• W. B. Saunders Co.	113
• Chatham Pharmaceuticals, Inc	163	• G. D. Searle Company	15
• Coca-Co'a Co.	169	• Silver Hill	
• Convention Press	167	• Smith, Kline & French	
• Duval Home	153	Surgical Supply Co	
• Endo Laboratories	171	• Tucker Hospital, Inc.	
• J. H. Filbert Inc.	122	• S. J. Tutag & Co	
• Hill Crest Sanitarium	168	• U. S. Vitamin & Pharmaceutical Corp. 156,	
• Johnson & Johnson	118a	Bob Wagner X-Ray	
• Lederle Laboratories	117, 160, 161, 172		
• Eli Lilly & Co.	126	• Wallace Laboratories	
• Medical Protective Co.	169	Westbrook Psychiatric Hospital, Inc.	
Medical Supply Co	163	• Winthrop Laboratories 112, 118,	
• Parke Davis & Co	Second Cover, 111	• Zeigler of Florida	16.

one answer...three minutes



COMBISTIX — Dip end

three answers

...ten seconds



mbistix

urine protein • glucose • pH

BASIC COMBINATION TEST FOR BEDSIDE AND OFFICE

... faster than taking temperature. Detects glucosuria (as in diabetes), proteinuria (as in renal disorder), abnormal pH (as in calcinosis or GU infection). For routine screening of all patients. Combistix—basic as the stethoscope.

AMES products are available through your regular supplier. 38263





Formerly nervous and tense, now better able to...

make decisions



This, in essence, is what happens when you place a patient on Librium (chlordiazepoxide HCl). Since this agent generally relieves anxiety and tension without dulling mental clarity or inducing drowsiness, most patients become better able to function normally, take an active interest in family and surroundings, meet and solve daily problems. This antianxiety agent is virtually free from extrapyramidal side effects, and does not produce or deepen depression.

Anxiety and tension relieved Alertness maintained

Librium

(chlordiazepoxide HCl) ROCHE

the successor to the tranquilizers

Dosage: Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or times daily. Side effects: Drowsiness and ataxia, usually dose-related, have been reported in some patients—particularly the elderly and debilitate Paradoxical reactions, i.e., excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions me be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other side effects, usually dose-related, have included isolat instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. Precautions: In elderly, debilitat patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advis against possibly hazardous procedures requiring complete mental alertness or physical coordination. Caution patients about possible combined effect with alcohol. Caution should be exercised in administering Librium (chlordiazepoxide HCl) to addiction-prone individuals. Careful consideration should be given to the pharmacology of any agents to be employed concomitantly—particularly the MAO inhibitors and phenothiazines. Observe us precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. Caution should be exercised in prescribing any therapeutic agent to pregnant patients.

September, 1963

Vol. 50, No. 3

The JOURNAL

of the Florida Medical Association

SUBAORTIC STENOSIS

BENIGN ADRENOCORTICAL ADENOMA

SPONTANFOUS PNEUMOTHORAX

MFDICAL RESEARCH
UNIVERSITY OF FLORIDA

FUNGUS INFECTIONS OF THE SKIN





whatever the shape or form of allergy...

Benadry (Diphenhydramir hydrochloride)

effectively relieves the symptoms of vasome rhinitis. For patients sensitive to animal danders, this constitution provides twofold therapeutic action to help abort an all attack. Antihistaminic action: A potent antihistaminic breaks the cycle of allergic response, bringing relief of support of the sense of the cycle of allergic response, bringing relief of support of the cycle of allergic response.



acrimatian, nasal blackage, and rhinorrhea. Antispasic action: Because of its inherent atrapine-like erties, the drug affards cancurrent relief af bronchial 1. Indications: Allergic diseases such as hay fever, zic rhinitis, urticaria, angiaedema, bronchial asthma, ı sickness, atapic dermatitis, cantact dermatitis, gastroinal allergy, vasomatar rhinitis, pruritus, physical allerreactions to injection of contrast media, reactions to peutic preparations, and allergic transfusion reactions; postaperative nausea and vomiting, nausea af pregr, matian sickness, parkinsanism and drug-induced pyramidal reactions, and quieting emotionally disturbed en. Parenteral administration is indicated where, in the nent of the physician, prampt action is necessary and therapy would be inadequate. Precautions: Avaid taneous ar perivascular injectian. Single parenteral dasreater than 100 mg. should be avoided, particularly in hypertensian and cardiac disease. Persons who have became drowsy an this ar other antihistamine-containing drugs, ar whose talerance is not known, should not drive vehicles ar engage in other activities requiring keen response while using this product. Hypnotics, sedatives, ar tranquilizers, if used with this product, should be prescribed with cautian because of passible additive effect. Diphenhydramine hydrochloride has an atrapine-like action which should be considered when prescribing it. Cream (Ointment) should not be applied to extensively denuded ar weeping skin areas. **Supplied:** Kapseals® of 50 mg.; Capsules of 25 mg.; Emplets® (enteric-caated tablets) of 50 mg.; in aqueous salutians: 1-cc. Ampaules, 50 mg. per cc.; 10- and 30-cc. Steri-Vials,® 10 mg.per cc. with 1:10,000 benzethonium chlaride as a germicidal agent; Elixir, 10 mg. per

4 cc. with 14 per cent alcohal; 2 per PARKE-DAVIS cent Ointment (water-miscible base).



NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

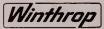
NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

NTz® Nasal Spray

NTz is more than a simple vasoconstrictor. It contains Neo-Synephrine® HCI 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; Thenfadil® HCI 0.1% for topical antiallergic action; and Zephiran® CI 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium as chloride, refined), trademarks reg. U. S. Pat. Off.



Winthrop Laboratories New York 18, N.Y.

The JOURNAL

of the Florida Medical Association

Volume 50, Number 3, September 1963

THIS ISSUE

Articles

THAD	MOSELEY,	M D
111110		141.10
	Editor	

SHALER RICHARDSON, M.D. Editor Emeritus

Assistant Editors

CHARLES K. DONEGAN, M.D. FRANZ H. STEWART, M.D. JOHN M. PACKARD, M.D.

THOMAS R. JARVIS Managing Editor

LOUISE RADER
Assistant
Managing Editor

EDITH B. HILL Editorial Consultant

Published monthly at Jacksonville, Florida. Price \$7.00 a year: single numbers, 70 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville, Fla., 32203, Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103. Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

William H. Bernstein, M.D. and Raymond A. Justi, M.D.	
Benign Adrenocortical Adenoma Producing Cushing's Syndrome in an Infant, William W. Cleveland, M.D. and	•
Michel G. Gilbert, M.D.	199
Spontaneous Pneumothorax, M. Murray Schechter, M.D.	203
Medical Research at the University of Florida	207

Editorials

The Third Party in Medicine, Robert B. Smallwood, M.D.	222
Bacterial Sensitivity, Frank M. Woods, M.D.	222

Features

President's Page	221
Dermatology Page—Fungus Infections of the Skin	220
Meetings	219
Association News	223
Letters	224
News	228
Classified	231
Florida Medical Association Officers and Council Chairman	254

This Journal is not responsible for the opinions and statements of its contributors. Owned and published by the Florida Medical Association.



clear the tract with Robitussin®

When summer coughs make the rounds and interfere with work and play schedules, Robitussin "clears the tract" safely. Glyceryl guaiacolate, the expectorant agent, increases respiratory tract fluid (R.T.F.) almost 200%. Increased R.T.F. helps flush mucous plugs and other irritants from the bronchi to make coughs more efficient. In the treatment of coughs in 425 infants and children, Blanchard and Ford found that Robitussin "...passed all criteria for clinical usefulness and is highly recommended." After more than thirteen years and millions of prescriptions, no serious side effects have been reported from Robitussin. Acceptance by infants and older children has been outstanding.

*Blanchard, K., and Ford, R. A.: Clin, Med., 3.961, 1956.

Robitussin®—each 5 cc. tsp. contains: Glyceryl guaiacolate......100 mg. Alcohol 3.5%

A. H. Robins Company, Incorporated Richmond 20, Virginia



STARTING TOMORROW MORNING this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule® Trademark brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' Spansule capsule taken in the morning.

SIDE EFFECTS: Insomnia, excitability and increased

motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules,

Smith Kline & French Laboratories Prescribing information Jan. 1963





Flavor you never thought you'd get from any filter cigarette!

You'll never know how satisfying filter smoking can be until you try Tareytons. Fine, flavor-rich tobaccos go into each Tareyton. Then the famous

Dual Filter <u>brings out</u> the best taste of these choice tobaccos. Sound too good to be true? Pick up a pack of Tareytons today and see for yourself.





For comprehensive control of the whole pain complex...

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component — chlor-mezanone — 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the whole pain complex — with unsurpassed tolerance.

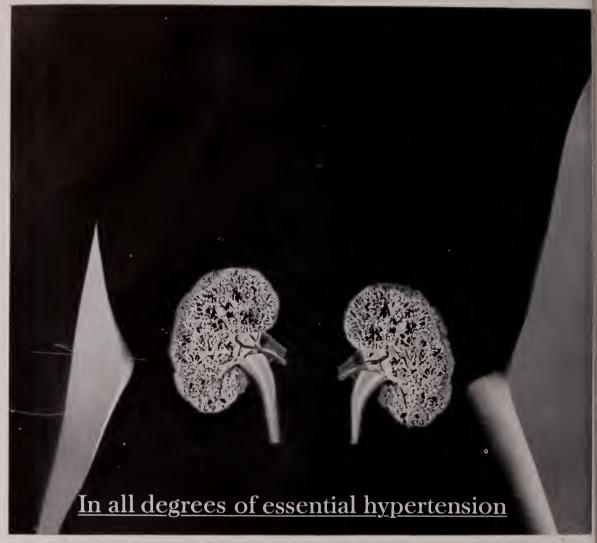
Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily. Reactions to Trancogesic have been minor — gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contrainindicated in persons known or suspected to have an idiosyncrasy to aspirin.

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

TRANCOGESIC*
CHLORMEZANONE with ASPIRIN
100 MG.
300 MG.



1777M



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced. 1-2 "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality. "1 Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients. Rautrax-N is effective in mild, 3 moderate, 3,4 or severe hypertension. 4,5

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycos-

uria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. Rautrax-N Modified—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief. References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. 9:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. 63:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. 10:516 (June) 1962. (4) Hutchison, J. C.: Current Therap.

J. C.: Current Therap. Res. 4:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: 23:248 (June) 1962.

Squibb Quality

—the Priceless Ingredient

squibb Division Olin



RAUTRAX*-N RAUWOLFIA SERPENTINA WHOLE ROOT (50 MG.), BENDROFLUMETHIAZIDE (4 MG.) WITH POTASSIUM CHLORIDE (400 MG.), SQUIBB



Both the Cream and Ointment rarely sensitize and are bactericidal to virtually all gram-positive and gram-negative organisms found topically, including Pseudomonas aeruginosa and Staphylococcus aureus.

Indications: Wherever infection occurs and is accessible for topical therapy.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

'NEOSPORIN' brand POLYMYXIN B / NEOMYCIN / GRAMICIDIN ANTIBIOTIC CREAM

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Gramicidin 0.25 mg.

In a smooth, while, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, distilled water, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax and 0.25% methylparaben as preservative.

*U.S. Patent Nos. 2,565,057-2,695,261

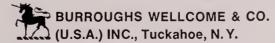
Available: In 15 Gm. tubes.

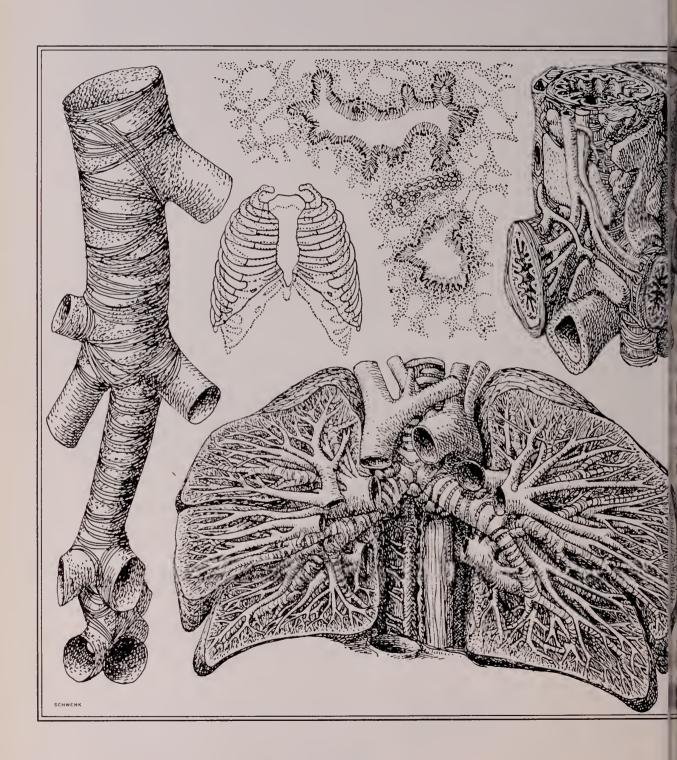
NEOSPORIN'® brand POLYMYXIN B / BACITRACIN / NEOMYCIN ANTIBIOTIC OINTMENT

Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base).

Available: Tubes of 1 oz., 1/2 oz. and 1/8 oz.

Complete literature available on request from Professional Services Dept. PML.





188 Volume 50, Number 3

ir Rights

n ARISTOCORT Triamcinolone, many matic patients obtain early gratifying f of wheezing, dyspnea and spasmodic hing. And maintenance dosage in many s can be surprisingly low - often as little single 2 mg. tablet per day. Yet it pros this symptomatic control—which may le many patients to continue their cusary livelihoods or regular household vities—with only minimal interference other metabolic functions. In this respect. STOCORT Triamcinolone is distinhed compared with other corticosteroids, and new. Typical steroid problems of im retention and edema, euphoria, or cious appetite and excessive weight gain ly occur.

STOCORT Triamcinolone is indicated anti-inflammatory, anti-allergic action accordicoids is desired. SIDE EFFECTS of glucocorticoids generally: Cushingoid effects, hirsutism, leucopenia, purpura, vertigo, fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

PRECAUTIONS: ARISTOCORT Triamcinolone should be used with extreme caution in viral infection, particularly herpes simplex and chicken pox, in tubercular or fungal infection, in active peptic ulcer, acute glomerular nephritis or myasthenia gravis. FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup—2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

Aristocort Triamcinolone

eximum steroid benefits with minimum steroid penalty

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

J. Florida M.A./September, 1963

189



HOW TO BE SURE your young patients get the aspirin dosage you want them to have

The answer is Orange Flavored Bayer Aspirin for Children The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

For professional samples, just write The Boyer Company, Dept. 112, 1450 Broodway, New York 18, New York.



blood, mik and Maalox® (magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for perforated ulcer. Why is Maalox included? Antacid therapy must continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation - three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



Get your
low-back patient
back to work
in days
instead of weeks

You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG, TABLET Q.I.D.

The muscle relaxant with an <u>independent</u> pain-relieving action

Soma[®] carisoprodol

W.

Wallace Laboratories Cranbury, New Jersey





in alcoholism: vitamins are therapy

full "comeback" for the alcoholic is partly dependent on nutritional balance... ded by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient seriously undernourished...from long-standing dietary inadequacy, from deplement of basic reserves of water-soluble vitamins.

ch capsule contains: Vítamín B₁ (Thiamine Mononitrate)...10 mg. / Vítamín B₂ (Riboflavin)...10 mg. / Niacinamide... ¹ mg. / Vítamín C (Ascorbic Acid)...300 mg. / Vítamín B₆ (Pyridoxine HCl)...2 mg. / Vítamín B₁₂ Crystalline... ncgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vítamín ficiencies. Supplied in decorative "reminder" jars of 30 and 100.





LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS® Stress Formula Vitamins Lederle



This is the key that opens the box that contains the labels. Only authorized supervisory personnel have the key to transfer labels from the "lockup box" to the labeling machine.

These responsible Lilly employees regard labels as serious business. To make certain that the right label appears on each container, all labels are kept under lock and key until needed on the finishing line. Only the quantity needed to

finish the lot is dispensed. When transferred the finishing belt, the appropriate numb of labels is placed in the labeling machin Excess labels are put in the lockup be until needed. At night, the supervisor return unused labels to the box lest some get lost misplaced. This is just one more precautic in an endless list of rules that contribute immeasurably to the quality of the finished produc

The JOURNAL

of the Florida Medical Association

Idiopathic Hypertrophic Subaortic Stenosis

A Case Report

PHILIP SAMET, M.D., WILLIAM H. BERNSTEIN, M.D. MIAMI BEACH AND RAYMOND A. JUSTI, M.D.

Several varieties of fixed left ventricular outflow tract obstruction have been identified. These include the supravalvular, valvular and subvalvular forms of aortic stenosis; all three are amenable to surgical intervention. The purpose of this case report is to detail another class of left ventricular outflow obstruction that was first recognized in 1957.2

Report of Case

A 37 year old Negro woman was first admitted to Mount Sinai Hospital in November 1957. Apart from several episodes of lightheadedness and palpitation in 1951 she was asymptomatic until June 1957. She was para IX, gravida IX and all nine children were alive and

well; the youngest was five years old.

In June 1957 recurrent episodes of paroxysmal tachycardia, weakness and dyspnea developed. She was hospitalized and digitalized elsewhere at this point. The episodes of tachycardia disappeared, but mild exertional dyspnea became evident. She continued working as a maid. She was then examined in the cardiac clinic and was hospitalized for cardiac catheterization when a pre-cordial murmur was heard. On physical examination, the blood pressure was 115/65 mm. Hg, pulse 76, brisk and bounding, and respiratory rate 20. The temperature was normal. No evidence of heart failure was noted. The positive physical findings were limited to the heart. The cardiac point of maximal impulse was in the fifth left interspace outside the midcavicular line. Thrills, rub, gallop and diastolic murmurs were absent. A grade 3 (of 6) ejection type of systolic murmur was heard maximally at the third left interspace just to the left of the sternum and was transmitted to the aortic area and apex. The radial pulse was normal to palpation. On cardiac fluoroscopy and x-ray, mild left ventricular enlargement was observed (fig. 1); a barium esophagram revealed 1 plus left atrial enlargement. The right heart was normal. Intracardiac valvular calcifications were absent. The electrocardiogram revealed left axis deviation and was suggestive of left ventricular hypertrophy (fig. 2). Blood chemistry studies were nonrevealing. The blood count and urine were normal. The admission differential diagnosis rested between congenital interventricular septal defect and rheumatic mitral insufficiency. The physical

From the Cardio-Pulmonary Laboratory, Mount Sinai Hospital, Miami Beach, the Section of Cardiology of the Department of Medicine, University of Miami School of Medicine, Coral Gables, and the Medical Examiner's Office, Dade County.

findings were, however, considered atypical for either diagnostic possibility

Right heart catheterization on Dec. 3, 1957, revealed no evidence of a left to right shunt by blood oxygen and nitrous oxide analyses. Right heart pressures and brachial artery pressures were normal at rest and during exercise. The cardiac index was moderately reduced at rest, 2.32 L./Min./M². The exercise cardiac output increment was well within normal limits,3 1,190 ml. exercise output increase per hundred milliliters exercise increment in oxygen consumption. Left ventricular catheterization by the left atrial posterior percutaneous punc-ture technique demonstrated a large mean systolic left ventricular-brachial artery gradient indicating left ventricular outflow tract obstruction. The brachial artery pressure curve (figs. 3 and 4) revealed a sharp upstroke, unlike the slow prolonged rise pattern commonly noted in valvular aortic stenosis. No evidence of mitral insuffici-ency was noted. The patient refused surgical intervention for relief of the left ventricular outflow tract obstruction.

The patient was then followed in the cardiac clinic, Physical findings remained unchanged. Another full term pregnancy passed uneventfully. A second right heart catheterization in October 1960 again revealed normal right heart pressures at rest and exercise. The cardiac index was normal at rest $(2.70~L./Min./M^2)$. The exercise cardiac output increment was only 585, about half of the corresponding value in 1957. The patient continued to do well clinically, but one year later, October 1961, she

was found dead in bed one morning.

At postmortem examination the heart weighed 770 Gm. The coronary arteries were widely patent and were conspicuously free of atherosclerotic changes. Two to 3 mm. fibrotic foci were scattered throughout the interventricular septum and left ventricle. The endocardium was free of mural thrombi. The cardiac valves were normal. The aorta and great vessels were remarkably free from atherosclerosis. Marked hypertrophy of the septal and free wall of the left ventricle constituted the most obvious abnormal gross finding. Tissue sections from the ventricles and interventricular septum revealed fibrotic foci. The muscle fibers were widened and the nuclei markedly enlarged with intensely basophilic chromatin. A discrete area of subaortic left ventricular outflow tract obstruction was not observed at autopsy.

Discussion

Since Brock² first described the entity of "functional obstruction of the left ventricle," many reports of the clinical, physiologic and

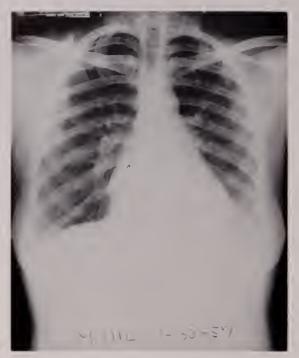


Fig. 1. — Posteroanterior chest film in 1957. The cardiac enlargement is predominantly left ventricular.

pathologic characteristics of this disease have been published.^{1,4-18} It has become apparent that the demonstration of a systolic pressure gradient between the left ventricle and the systemic arterial tree cannot be equated with the existence of an anatomic site of obstruction in the left ventricular outflow tract. The common causes of such a gradient—supravalvular stenosis, valvular stenosis and discrete fixed subvalvular stenosis—are amenable to surgical correction. The subject of this case report—idiopathic hypertrophic subaortic stenosis -is a less common etiology of a left ventricularsystemic arterial pressure gradient and is at present much more difficult to correct surgically. The importance of differentiation of this latter entity from the first three varieties of aortic stenosis is therefore self evident.

The anatomic deformity in hypertrophic subaortic stenosis consists of an area of diffuse muscular hypertrophy, especially of the septal musculature, in the left ventricular outflow tract which is especially evident during systolic contractions. During attempted open heart repair of the lesion, and at postmortem examination, no discrete area of stenosis is evident. Similar functional lesions have been observed in the right ventricular outflow tract. 19-22 Muscular hypertrophy in either ventricular outflow tract may also complicate valvular or discrete subvalvular stenosis at the aortic or pulmonic valve. Hypertrophic subaortic stenosis may in some instances be familial, 11,16-18 with suggestive evidence of a mendelian dominant inheritance. Although the major portion of the reported cases has been in the young adult age level, similar cases have been reported in the first decade of life. 22-23 A history of heart murmurs with unexplained sudden death among relatives is often obtained.

The severity of the lesion varies widely. In the mildest cases, only a systolic ejection murmur is present along the left sternal border with or without evidence of mild left ventricular hypertrophy on clinical, electrocardiographic and roentgenographic grounds. In this latter group left heart catheterization may even fail to reveal a systolic pressure gradient between the left ventricular outflow tract and the systemic arterial tree. In its more advanced form the disease process may result in a systolic pressure gradient without symptoms. When cardiovascular symptoms are present a large systolic pressure gradient has been observed across the left ventricular outflow tract.

The usual symptoms are easy fatigability, palpitation, exertional dyspnea, syncope, angina pectoris and right or left heart failure. Sudden death may occur as in valvular aortic stenosis. On physical examination the most prominent finding is a long harsh systolic ejection murmur most prominent at the apex and along the left sternal border. The murmur may be transmitted to the axilla or base of the heart but usually not the neck, unlike the findings in discrete valvular aortic stenosis. The murmur often suggests mitral insufficiency or ventricular septal defect at first blush. If the left ventricular outflow tract obstruction is severe, there are signs of left ventricular hypertrophy on physical examination, with a prominent apical thrust outside the midclavicular line. A systolic thrill may be observed at the apex or along the left sternal border, but is usually not felt at the aortic area or in the neck. The peripheral pulses are usually brisk or bounding, and the typical pulsus parvus of valvular aortic stenosis is not observed. Diastolic gallop sounds are frequently audible. Paradoxical splitting of the second heart sound may be evident on auscultation and phonocardiography. The diastolic blow of aortic insufficiency which so frequently accompanies valvular aortic stenosis is

Electrocardiography and roentgenography reveal left ventricular hypertrophy in patients with

severe outflow tract obstruction. Mitral insufficiency has been observed in some patients, and in these the left atrium may be enlarged. Aortic valvular calcification and dilatation of the ascending aorta are not present. Selective left ventricular angiocardiography or cineangiography is a most valuable diagnostic aid. A narrow left ventricular cavity is commonly demonstrated together with systolic reflux of dye into the left atrium. Mobility of the aortic valve leaflets is normal. Narrowing of the left ventricular outflow tract is especially evident during systole; during diastole the left ventricular cavity undergoes considerable enlargement. The area of systolic subvalvular left ventricle narrowing often has the appearance of an inverted cone.16

Left heart catheterization and systemic arterial cannulation provide characteristic if not pathognomonic data,1,5.10,15,16,21,23,24 Right heart catheterization is often normal in the absence of heart failure. On occasion a modest systolic pressure gradient may be observed between the right ventricle and pulmonary artery. Right heart pressures are otherwise normal at rest, but pulmonary artery pressures may rise slightly during exercise. Left atrial pressure is at the upper limits of normal or slightly elevated. The cardinal feature of the typical case is of course a systolic pressure difference between the left ventricle and a systemic artery. Since the site of obstruction is subvalvular, two levels of left ventricular pressure may be recorded with identical diastolic pressures. Aortic systolic pressure is identical to the lower ventricular systolic pressure level. Cardiac output may be normal or slightly depressed at rest; the exercise response also varies from minimal increments to normal increases during exercise.

Modest mitral insufficiency may be revealed by left ventricular angiography. Other angiographic findings have been previously mentioned. The systemic arterial pulse may be normal or more commonly fast rising as in aortic insufficiency.1 Brachfeld and Gorlin15 first described a rapid upstroke (percussion wave) and sharp incisura. The rapid upstroke is present because the left ventricular outflow tract obstruction is present after the initiation of ventricular contraction rather than at the onset of isometric contraction as in valvular aortic stenosis. A secondary rise (tidal wave) is often present producing a double systolic pressure wave in the aortic and peripheral arterial pressure curve.8 These findings are quite different from the systemic arterial pres-

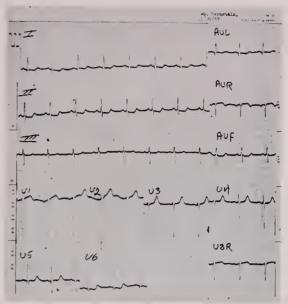


Fig. 2. — Electrocardiogram in 1957 demonstrates left ventricular hypertrophy.

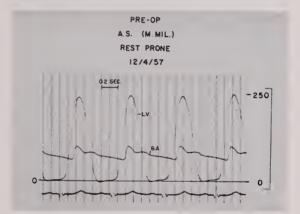


Fig. 3. — Simultaneous left ventricular and brachial artery pulse pressures. The systolic gradient and the rapid brachial artery upstroke are seen.

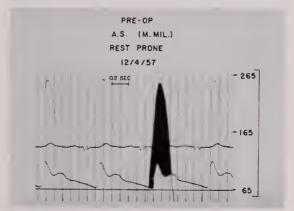


Fig. 4. — Left ventricular and brachial artery curves from another base line, 65 mm. Hg. Note the quick brachial artery upstroke.

sure curves observed in fixed discrete left ventricular outflow obstruction. Braunwald, Brockenbrough and Morrow⁶ summarized many of the hemodynamic features of this disease. They described variability of left ventricular outflow tract obstruction during a single cardiac cycle as demonstrated by selective left ventricular angiography. Marked left ventricular cavity narrowing is present during systole while relaxation of the outflow tract occurs during diastole.

In addition, variability of the severity of systolic obstruction has been observed in the same patient. In patients with fixed discrete left ventricular outflow tract obstruction, such as valvular aortic stenosis, the first ventricular and systemic arterial pulse pressures following the compensatory pause after a ventricular premature beat are characterized by increased ventricular systolic pressure and a larger systemic arterial pulse pressure. 10 By contrast a smaller systemic arterial pulse pressure has been observed in the first arterial beat following the compensatory pause after a ventricular premature beat in patients with idiopathic hypertrophic subaortic stenosis. The latter finding occurs because the size of the obstructed outflow opening is a measure of the vigor of left ventricular contraction; the more powerful contraction after the premature beat causes a greater than usual narrowing of the left ventricular outflow tract.

Digitalis glycosides may increase the systolic pressure gradient between the left ventricle and systemic artery in hypertrophic subaortic stenosis by producing an increase in left ventricular contractile force.7 One patient, studied twice at an interval of several days, exhibited a left ventricular systemic arterial gradient of 45 mm. Hg on the first study but no gradient on the second study although the cardiac outputs were almost identical on the two occasions. Other patients⁷ were observed to have 75 mm. Hg gradients during left heart catheterization but absent gradients at subsequent thoracotomy. Braunwald and Ebert⁵ reported that intravenous isoproterenol (Isuprel) administration increased the systolic pressure gradient in hypertrophic subaortic stenosis while the cardiac output was lowered. On

the other hand, methoxamine (Vasoxyl) administration abolished the left ventricular systemic arterial systolic pressure gradient in three patients with this disease. These observers postulated that the latter two drugs, isoproterenol and methoxamine, acted by producing changes in left ventricular outflow muscular contractibility.

Braunwald, Brockenbrough and Morrow⁶ also demonstrated variations in the severity of obstruction in different members of the same family. Similar clinical pictures, namely, signs of left ventricular hypertrophy and a systolic murmur along the left sternal border, were present even in the absence of a systolic pressure gradient. The detailed anatomic data may help explain why such gradients are observed in some subjects but are absent in others in whom superficially similar anatomic observations have been made. Speculations have been advanced that at least some patients with idiopathic left ventricular hypertrophy may in reality be examples of hypertrophic subaortic stenosis.

Treatment for patients with idiopathic hypertrophic subaortic stenosis is difficult at present.²⁵ Diuretic therapy is indicated in the presence of heart failure but digitalization may be contraindicated.⁷ Surgical therapy of the ventricular outflow tract obstruction has not been corrective because of the diffuse character of the muscle hypertrophy, but several groups are exploring the potential value of muscle resection.^{26,27}

Summary

A case is reported in which the patient exhibited the clinical and laboratory features of idiopathic hypertrophic aortic stenosis. Because of the difference in surgical results in this type of left ventricular outflow tract obstruction as compared to fixed discrete outflow tract obstruction, as in valvular aortic stenosis, it is important to make a preoperative diagnosis of hypertrophic subaortic stenosis. The clinical, hemodynamic, and angiocardiographic findings usually permit such a differentiation.

References are available from the authors upon request,

University of Miami School of Medicine.

Benign Adrenocortical Adenoma Producing Cushing's Syndrome in an Infant

WILLIAM W. CLEVELAND, M.D. AND MICHEL G. GILBERT, M.D.

MIAMI

One of the most common reasons for referral of a child to an endocrine clinic is obesity. The vast majority of such patients do not have endocrinological or other disease, and the condition is diagnosed as exogenous obesity. Of the endocrinological causes of obesity, Cushing's syndrome is practically the only one of significance and needs, therefore, to be excluded. It seems clear that the clinical features of this syndrome are due to the effects of excess adrenocortical hormones. The lesion in the adrenal gland may be tumor or hyperplasia. Tumors are probably completely autonomous in their action, but some confusion exists regarding the role of excessive stimulation by the pituitary body as a cause of adrenal hyperplasia and Cushing's syndrome. Cushing1 originally attributed this disease to the effects of a basophilic adenoma of the pituitary body, and more recently the relationship between adrenal hyperplasia and pituitary tumors has been re-emphasized, suggesting that Cushing's original concept may be correct in a large number of instances.2 This controversy regards adrenal hyperplasia, however, rather than adrenal tumor as a cause of the syndrome. In children adrenal tumor is present in the large majority of cases. Only five cases of adrenal hyperplasia producing Cushing's syndrome in children under 10 years of age have been reported in the available literature.3-7 Various reports and reviews3.21 indicate that approximately 40 cases of Cushing's syndrome due to tumor have been reported. In all but seven of these cases malignant tumors were present. It is, therefore, rare to find benign adenoma of the adrenal gland producing Cushing's syndrome in which surgical cure is achieved. Such a case is here reported.

Report of Case

A 10 month old male infant was referred to the Endocrine Clinic of the Variety Children's Hospital for

From the Departments of Pediatrics and Surgery, University of Miami School of Medicine, and Variety Children's Hospital, Miami.

evaluation of marked obesity (fig. 1). The birth weight was 9 pounds 7 ounces, and the child was reported to have been obese with an unusually large appetite all of his life. Hypertrichosis and pubic hair had been present for approximately two months. A "rash" had been present on the cheeks for approximately the same period of time. He had otherwise been well. Two siblings, a girl aged nine and a boy aged seven, were normal, and there was no history of obesity or endocrine disease in the family.

Physical Examination.—The weight was 28 pounds, length 28 inches, and blood pressure 130/80 mm. Hg. There was marked and generalized obesity. The facies was typical of the Cushing syndrome. Although the skin was plethoric, there were no significant striae. Generalized hypertrichosis with increased growth of hair over the spine was present; there was a light growth of pubic hair, but the penis was not significantly enlarged. An acneiform eruption with pustules was present on the cheeks and forehead. No unusual bruises were noted. On abdominal examination no masses could be felt. Examination was otherwise negative.

Laboratory.—The hemoglobin estimation was 12.6 Gm., the hematocrit reading 42, and the white blood cell count 13,000 with a normal differential. Urinalysis gave normal results. The serum chemistry included sodium 140 mEq/L, chlorides 107 mEq/L, carbon dioxide 24 mEq/L, blood urea nitrogen 14 mg. and fasting blood sugar 109 mg. per hundred cubic centimeters. Measurements of steroid excretion are listed in table 1.

On radiologic examination, the chest was within normal limits, the skull showed minimal osteoporosis with no deformity of the sella turcica, and the long bones displayed osteoporosis. There was an increase in subcutaneous fat, and a skeletal age of 15 months. An intravenous pyelogram demonstrated a lateral and inferior displacement of the left kidney by a mass approximately 5 cm. in diameter, with a normal urinary tract on the right side (fig. 2).

Hospital Course.-After the base-line evaluations, an ACTH-adrenal suppression test was performed according to the method of Liddle,22 by the administration of dexamethasone. Suppression did not occur (table 1), supporting the diagnosis of adrenal tumor. The child was prepared for operation by administration of cortisone acetate, 150 mg. intramuscularly daily for two days prior to and on the day of the operation. On Dec. 21, 1960, with the patient under general endotracheal anesthesia, a 5 cm. well encapsulated yellowish brown tumor was easily removed intact from the left adrenal gland through a left subcostal incision. No gross evidence of invasion was noted. The right adrenal gland was palpated and thought to be atrophic. Following the operation the patient was maintained on intravenous fluids with parenteral steroids as follows: first day, 75 mg, of cortisone acetate intramuscularly and 100 mg, of hydrocortisone intravenously; second day, 50 mg. of cortisone acetate intramuscularly and 60 mg. of hydrocortisone intravenously; third day, 25 mg. of cortisone acetate intramuscularly and 12.5 mg, of cortisone acetate four times a day by mouth. Thereafter the dosage of oral cortisone was gradually reduced so that at discharge on Jan. 19, 1961, the patient



Figure 1



Figure 2

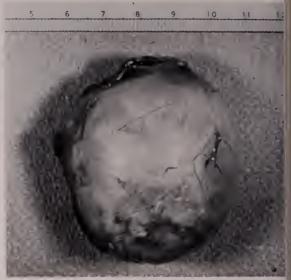


Figure 3

was receiving 5 mg. four times a day. Recovery was rapid with no complications.

Pathologic Findings. — Gross (fig. 3): A round well encapsulated yellowish brown mass measured 5 cm. ir diameter. Sectioning revealed yellowish brown tissue with a few small hemorrhages. Microscopic (fig. 4): A thick capsule of fibrous tissue covered the tumor. The tumor proper was made up of a rather uniform type of cells forming cords and irregular lobules. These cells had a finely granular eosinophilic cytoplasm with round to oval nuclei. Nucleoli were not present and mitotic figures were rare. There was no evidence of capsular invasion. Diagnosis: Adrenocortical adenoma.

Subsequent Course.—The dosage of cortisone was tapered and completely discontinued two months after the operation. At six weeks after operation 20 units of ACTH gel were given daily for three days. In the following months occasional bouts of otitis media with fever occurred, and during these illnesses cortisone was given prophylactically. A gradual change in appearance occurred with loss of the typical features, also loss in weight, increased linear growth, and disappearance of the acne. The excretion of 17-hydroxycorticoids diminished (table 1), and an intravenous pyelogram four months following the operation was normal. The rise in 17-hydroxy steroids during the past several months is believed to reflect increasing age rather than abnormal adrenal activity The child continues to be well approximately two years following removal of the tumor (fig. 5).

Discussion

Although obviously rare, Cushing's syndrome is one of the few disease entities producing obesity

Table 1.—Urinary Excretion of Steroids

Date	17 Hydroxy Steroids	17-Keto- Steroids	Remarks
12/14 60	2.1	3.2	Preoperative control
12 15 60	2.1	3.4	Preoperative control
12 '17 60	2.4	3.0	Second 24 hrs. of dexamethasone, 1.5 mg. every six hrs.
3 10,61	0.6		2½ mos. postoperatively; no steroid therapy
10 '20 '61	1.6		10 mos. postoperatively
11 17 61	0.4		11 mos. postoperatively
3 /21 /62	1.1	0.8	15 mos. postoperatively
11 19/62	1.5		23 mos. postoperatively

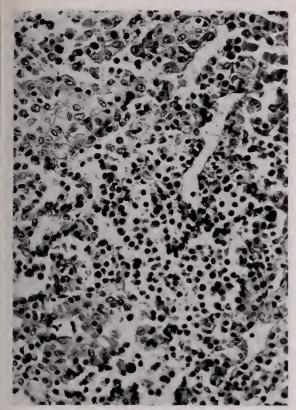


Figure 4

and needs to be considered in evaluation of infants and children with this problem. The clinical features of this disorder are now familiar to most physicians because of its occurrence following the frequent use of adrenocortical steroids in the treatment of various diseases. Certain aspects of the syndrome in infants and children are, however, worth mentioning. Although the obesity is said to be truncal in distribution, it will be noted that the distribution of fat in this patient, as in most infants with the disorder, is massive and generalized, involving the extremities as well as the trunk. The characteristic striae seen in older patients may, as in this instance, be absent. The "buffalo hump" type of accumulation of adipose tissue, while perhaps more striking in Cushing's disease, occurs in patients with obesity from any cause and, therefore, cannot be considered characteristic.

Hypertension, while more severe in this disorder, should not be confused with mild elevation of blood pressure occurring in many obese children, probably on the basis of artifact associated with measurement of blood pressure in the obese arm. Certain other distinguishing features, however, are most important. The child with exogenous obesity is usually taller than average while patients with Cushing's syndrome will be retarded in linear growth. The facies with ballooned and reddened cheeks is characteristic, and frequently a pustular acneiform eruption is present over the face and occasionally elsewhere. Although these features due to effects of excess glucocorticoid production predominate, frequently signs of some degree of virilization are present. This may be manifest by sexual hair and perhaps phallic enlargement and is reflected by increased excretion of 17-ketosteroids.

Laboratory evaluation of this patient revealed excretion values for 17-hydroxycorticoids of approximately 2.0 mg. a day, which were surprisingly low. Normal values for infants this age are not definitely established in this laboratory, but are on the order of 0.5 mg. daily so that the measured



Figure 5

values, however low, probably represent a significant increase above normal. Values for the 17ketosteroid excretion are more abnormal and not out of keeping with the degree of virilization observed clinically. Liddle22 has shown in adults that suppression of the ACTH-adrenal mechanism is of value in the diagnosis of Cushing's syndrome. It was found that excretion of 17-hydroxy steroids was suppressed by the administration of either \triangle 1-9 α fluorocortisol (\triangle FF) or its 16-methylated analog, dexamethasone. This effect is due to the fact that these steroids inhibit production of endogenous hormone but are administered in such small doses that they do not contribute significantly to the urinary steroid concentrations. By adjusting the dose of steroid administered, Liddle²² was able to distinguish normal patients from those with adrenal overactivity and, in the latter, to differentiate between those with hyperplasia and with tumor. Thus with 0.5 mg. of FF, or dexamethasone, every six hours for eight doses normal adrenal function was suppressed but hyperactivity was not. With doses of 2.0 mg. every six hours for eight doses patients with Cushing's syndrome due to adrenal hyperplasia showed suppression while those in whom the syndrome was due to tumor did not. This is believed then to be an important diagnostic tool for establishing the type of lesion producing Cushing's syndrome.

The test lacks value in children, however, since the suppressive dose has not been established, but is almost certainly less than the dose for adults. In our patient it was thought with confidence that an adrenal tumor was present, but an ACTHadrenal suppressive test was performed to evaluate its usefulness. An arbitrary dose of 1.5 mg. was chosen as one which would almost certainly be suppressive in a normal child or one with adrenal hyperplasia. This was administered every six hours for eight doses. There was no change in excretion of 17-hydroxy steroids (table 1), which is in keeping with the presence of an autonomously functioning adrenal tumor. In the interest of conserving time an ACTH stimulation was not done.

The clinical picture and laboratory studies will generally lead to an unequivocal diagnosis of Cushing's syndrome in children. The suppression test may give an important indication whether this syndrome is due to adrenal hyperplasia or tumor, but is not considered infallible. It is thought, therefore, that any child with this disorder should be subjected to a surgical exploration to establish with certainty the nature of the defect. This is particularly true in children since hyperplasia is so rare and a chance for surgical cure exists when tumor is found.

The management of Cushing's syndrome due to adrenal hyperplasia remains debatable although irradiation of the pituitary body is gaining favor as the treatment of choice. Treatment in the situation of adrenal tumor is clear cut. Proper preparation of the patient for operation is essential, however, since upon removal of the adenoma the patient will usually have no endogenous adrenal function. Preoperative administration of cortisone acetate, 100 to 200 mg. daily, intramuscularly for two days prior to and on the day of operation according to the regimen of Wilkins²³ is desirable. Following the operation cortisone must be administered in gradually diminishing dosage. Stimulation of the remaining adrenal tissue with ACTH may be helpful. In the several months or perhaps years following cure, exogenous steroids may be indicated at operation or during other stressful illness because of inability of the previously suppressed adrenals to respond normally.

It may be difficult to tell from either the gross or microscopic findings whether adrenal tumors are malignant or benign. Even in the absence of demonstrable local invasion or distant metastases recurrence may take place. It is important to follow such patients carefully for clinical signs of reappearing Cushing's syndrome and to measure periodically excretion of steroids. Our patient has been free of any abnormal findings for a period of two years, and it is believed that he represents the unusual case in which an adenoma of the adrenal gland has been completely removed to effect a permanent cure of the Cushing's syndrome.

This patient was referred with a diagnosis of Cushing's syndrome by Dr. Oliver D. Anderson, Hialeah.

References

- Cushing, H.: Basophil Adenomas of the Pituitary Body, and Their Clinical Manifestations, Bull. Johns Hopkins Hosp. 50:137-195 (Mar.) 1932.
 Wilkins, L.: Adrenal Disorders. I. Cushing's Syndrome and Its Puzzles, Arch. Dis. Childhood 37:1-8 (Feb.) 1962.
 Hubble, D. V., and Illingworth, R. S.: Adrenocortical Hyperplasia in Childhood, Arch. Dis. Childhood 32:285-292 (Aug.) 1957.
 Goldblatt, E., and Snaith, A. H.: A Case of Cushing's Syndrome in an Infant, Arch. Dis. Childhood 33:540-542 (Dec.) 1958.

- 1958.
 Sobel, E. H., and Taft, L. T.: Cushing's Syndrome and Mental Suspected Retardation in an 18 Month-Old Boy, Pediatrics 23:413-418 (Feb.) 1959.
 Silver H. K., and Ginsburg, M. M.: Cushing's Syndrome in an Eight Year Old Girl, A.M.A. J. Dis, Child. 100:405-411 (Sept.) 1960.
 Thursby-Pelham, D. C., and Crowe, G. G.: Cushing's Syndrome in Childhood Due to Adrenal Hyperplasia, Brit. M. J. 52:1536-1539 (Dec. 9) 1961.
 Lightwood, R.: Tumour of the Suprarenal Cortex in an Infant of 18 Weeks, Arch. Dis. Childhood 7:35-42 (Feb.) 1932.

- Marks, T. M.; Thomas, J. M., and Warkany, J.: Adrenocortical Obesity in Children, Am. J. Dis. Child. 60:923-942 (Oct.) 1940. Chute, A. L.; Robinson, G. C., and Donohue, W. L.: Cushing's Syndrome in Children, J. Pediat. 34:20-39 (Jan.)
- Sobel, E. H.; Lee, C. M. Jr.; Esselborn, V. M., and Clark, L. C. Jr.; Functioning Adrenal Tumors in Childhood; Consideration of Diagnosis, Surgical Approach, and Postoperative Management, A.M.A. J. Dis. Child, 86:733-/51 (Dec.)
- ative Management, A.M.A. J. Dis. Child., 86:733-731 (Dec.)
 Powell, L. W. Ji.; Newman, S., and Hooker, J. W.: Cushing's Syndrome: Report of a Case in an Infant 12 Weeks Old, A.M.A. J. Dis. Child. 90:417-420 (Oct.) 1955.
 Guin, G. Il., and Gilbert, E. F.: Cushing's Syndrome in Children Associated with Adrenal Cortical Carcinoma; Case Report with Review of Literature, A.M.A. J. Dis. Child. 92:29-307 (Sept.) 1956.
 Peterman, M. G.: Suprarenal Tumor (Cushing's Syndrome), J. Pediat, 50:59-65 (Jan.) 1957.
 Greenblatt, R. B.; Martinez Manautou, J.; Zimmerman, A. M., and Lucas, W. T.: Cushing's Syndrome in Infancy, A.M.A. J. Dis. Child. 94:691-695 (Dec.) 1957.
 Heinbecker, P.: O'Neal, L. W., and Ackerman, L. V.: Functioning and Nonfunctioning Adrenal Cortical Tumors, Surg, Gynec, & Obst. 105:21-33 (July) 1957.
 Jackson, W. P.; Zillberg, B.; Lewis, B., and McKenzie, D.: Cushing's Syndrome in Childhood; Report of Case of

- Adrenocortical Carcinoma with Excessive Aldosterone Production, Brit. Med. J. 5089:130, 1958.
 Krauss, H., and Krainick, H. G.; Cushing's Syndrome in a 1½ Year Old Girl; Recovery After Excision of an Adrenal Cortex Adenoma, Deutsche med. Wchnschr. 83:321-324 (Feb. 28) 1958.
- Kogut, M. D., and Donnell, G. N.: Cushing's Syndrome in Association with Renal Ganglioneuroblastoma, Pediatrics 28:566-577 (Oct.) 1961.

- 2N:566-577 (Oct.) 1961.
 Puzynski, D. L., and Biehusen, F. C.: Adrenocortical Adenoma with Cushing's Syndrome and Virilism in a 5-Year Old Child., J. Pediat. 60:836-840 (June) 1962.
 Scott, H. W.; Liddle, G. W.; Harris, A. P., and Foster, J. II.: Diagnosis and Treatment of Cushing's Syndrome, Ann. Surg. 155:696-710 (May) 1962.
 Liddle, G. W.: Tests of Pituitary-Adrenal Suppressibility in the Diagnosis of Cushing's Syndrome, J. Clin. Endocrinol. 20:1539-1560 (Dec.) 1960.
 Wilkins, Lawson: The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence, Springfield, 111., Charles C. Thomas Publisher, 1957.

1600 Northwest Tenth Avenue (Dr. Cleveland). 637 Dupont Building (Dr. Gilbert).

Spontaneous Pneumothorax

Some Special Features and a Program of Therapy

M. MURRAY SCHECHTER, M.D. MIAMI

Spontaneous pneumothorax, according to present consensus, results from the rupture of a bleb or cyst of the lung. Hammond pointed out that spontaneous collapse of the lung may result also from rupture of the mediastinal pleura in spontaneous mediastinal emphysema. The visceral subpleural space is occupied by a layer of lung tissue consisting of potential spaces which have the ability to increase into cystlike dilatations since they are in direct communication with the alveoli or bronchioles.

To the chest physician, spontaneous pneumothorax may be a relatively common yet dramatic problem; however, other practitioners may view the disorder differently. There is a need for criteria which would make it possible for each individual patient to be rapidly evaluated and a decision reached on proper management.

Several theories have been presented evaluating the conservative versus the operative approach to the disorder, and the conclusions usually depend upon the point of view of the author. Several articles have appeared stressing the advantages of surgery and pointing out, in particular, the prolonged period of inactivity and hospitalization which is said to accompany normal re-expan-

sion without surgery. In this report, a series of 40 patients is presented and the therapeutic program described. In addition, criteria are outlined as a possible assistance in the proper management of the particular patient.

The patients in this series were admitted to the United States Air Force Hospital at Eglin Air Force Base, Florida, and the therapy on admission usually depended upon the medical officer on duty at the time. In the majority, skin tests and serial roentgenograms established the etiology, estimation of fluid accompanying the collapse and the side of the chest affected. The history provided the sex and age of the patient and the number of previous attacks, if any. The sex distribution has no significance in this series since the vast majority of the population served were male.

Clinical Manifestations

All the patients were symptomatic with the most common symptom described as a sharp pleuritic pain usually in the anterior or lateral chest wall. Other symptoms included dyspnea, nonproductive cough and cyanosis. They were generally more pronounced when the extent of collapse exceeded 50 per cent and became less so as the in-

Instructor in Clinical Medicine, University of Miami School of Medicine, Miami,



Fig. 1.—Spontaneous pneumothorax on the right side with approximately 20 per cent collapse. This lung reexpanded normally on conservative therapy in 11 days.

volved area decreased. There was no obvious relationship to exertion or activity and several episodes occurred during sleep.

The extent of collapse of the lung, estimated in each patient on the basis of roentgenograms of the chest, ranged between 10 per cent and 90 per cent with the average approximately 50 per cent. Skin tests, with old tuberculin or purified protein derivative, performed on 29 of the 40 patients gave negative results in 20. Of the 40 patients, the left side was involved in 20, the right side in 18; one had a bilateral pneumothorax, and one had pneumothorax confined to the anterior mediastinum. One third of the patients had had previous attacks and two had had as many as five. In 11, collapse was associated with fluid, generally a serous type effusion. The etiology was believed to be a bleb in 37 of the 40 patients, tuberculosis in one, and in two it was questionable. Recurrent collapse seemed to be unrelated to the type of therapy used during the previous attack. The average age of the group was approximately 24, and there were 38 males and two females (figs. 1-6).

Therapy

Three general types of treatment were employed in the series: conservative, allowing nor-



Fig. 2.—Spontaneous pneumothorax on the left side with 20 per cent collapse and slight fluid. This lung re-expanded normally on conservative therapy with the patient engaged in full activity.

mal re-expansion without surgical intervention; catheter drainage with water seal, and needle aspiration of air with or without water drainage.

With conservative therapy, the extent of complications and the discomfort of the patient were not increased significantly despite the increased duration of collapse and of hospitalization. This type of therapy usually was applied to patients having less than 50 per cent collapse, and in those with more than 50 per cent, surgical therapy usually was applied.

With surgical intervention, the duration of symptoms and of hospitalization was considerably less generally, and when surgical intervention consisted of catheter drainage, this was very obvious. Where needle aspiration was attempted, however, the duration of collapse was as long or longer than when conservative treatment was employed, and in addition, the complications were greater. It should be pointed out that needle aspiration usually was performed as an emergency due to marked collapse and poor condition of the patient.

In those patients who were subjected to thoracotomy fluid was more prone to develop. While in this series no bronchopleural fistula developed, this danger is present with thoracotomy. A bronchopleurocutaneous fistula could conceivably develop in an otherwise uninfected patient in the



Fig. 3.—Spontaneous pneumothorax on the right side with approximately 50 per cent collapse. This lung reexpanded normally on conservative therapy in approximately 18 days.



Fig. 5.—Spontaneous pneumothorax on the left side with approximately 75 per cent collapse and pleural fluid. This lung expanded under catheter drainage except for persistence of fluid for two weeks postoperatively.



Fig. 4.—Spontaneous pneumothorax on the left side with approximately 85 per cent collapse. This patient was scheduled for surgery, but was asymptomatic. He was instead treated conservatively and had normal reexpansion in 55 days without difficulty.



Fig. 6.—Spontaneous pneumothorax on the left side with approximately 90 per cent collapse and pleural fluid. The lung was treated with needle aspiration and incomplete re-expansion resulted. After the second aspiration, expansion was complete except for persistence of fluid for approximately two weeks.

event he was subjected to thoracotomy, and in addition the problem of pain and mediastinal shift is present if bronchial plugging exists.

In the group treated conservatively, the duration of collapse was approximately 14 days, and in the group treated with surgical intervention, including needle aspiration and catheter drainage, the duration of hospitalization was 24 days. When this latter group was broken down for comparison between needle aspiration and catheter drainage, there was an obvious difference. Those patients treated with needle aspiration required an average of approximately 26 days of re-expansion and elimination of fluid, and those treated with catheter drainage required an average hospital stay of approximately seven days. It should be remembered, however, that the group treated conservatively represents those patients with the extent of collapse measuring less than 50 per cent and without complications. Those treated operatively usually had complications, or the collapse exceeded 50 per cent. The important point is that minimal collapse without complications can be treated equally well with conservative therapy, and the results of treatment compare favorably with operative intervention.

Criteria for Treatment

In patients with spontaneous pneumothorax occupying less than 50 per cent of the chest cavity of the side involved and with no evidence of fluid, bleeding or embarrassment of respiration, the treatment should be conservative with limited activity and administration of analgesics and cough suppressants. Observation should be continued until re-expansion is complete. This will take place in almost 100 per cent of patients without significant difficulty including fever or infection. When the collapse exceeds 50 per cent of the chest cavity on the side involved or if there is bleeding, circulatory collapse or respiratory embarrassment, then an intrathoracic catheter should be employed with underwater drainage for a period of approximately 24 hours. Surgical resection rarely should be employed, if at all, in a young patient.

Considerable difficulty has been observed when talc or other methods have been used in an attempt to seal visceral and parietal pleura together. Such methods are yet in the experimental stage and probably do not represent a solution to recurrent pneumothorax at this time.

There is a tendency to treat all cases of spontaneous pneumothorax as a surgical emergency,

taking the patient to the operating room immediately upon admission to the hospital. It is my belief that when the optimum conditions as described are present, the emergency will pass within a few hours and the patient may then be treated conservatively without surgical intervention. After it is obvious that re-expansion is continuing at a normal rate, he may be discharged from the hospital and can be followed as an outpatient. Some patients even may be returned to activity under observation.

Surgical treatment for every patient with spontaneous pneumothorax will lead to increased complications including infection, empyema and occasionally the occurrence of bronchopleurocutaneous fistula. Addressing the National Tuberculosis Association in 1952, Daughtry and Chesney described the discomfort which may result during surgical decompression of the pneumothorax, particularly if the air leak is sealed and the collapsed lung fails to aerate well because of retained mucus. In such instances, the expulsion of air from the pneumothorax space results in shift of the mediastinum, with a resultant state of mild shock and pain. Surgical therapy should not be discouraged; however, the average physician should use discretion before it is employed.

Summary

A series of 40 patients with spontaneous pneumothorax is presented, and in several the condition was recurrent. An evaluation of various factors observed in this group together with an opinion as to the therapy and criteria for therapy is discussed. Generally, spontaneous pneumothorax causing less than 50 per cent collapse on the side involved, without respiratory or circulatory embarrassment, evidence of progressive leakage or pleural fluid, may be treated by conservative methods with limited activity, rest and administration of analgesics. With conservative treatment, re-expansion may require a longer period, but it is generally associated with fewer complications and they will be less severe in the event they do occur. The patient must be followed to be certain that aggressive re-expansion occurs. None of the patients in this series, however, experienced a "rind" or permanent collapse. Collapse in excess of 50 per cent is best treated probably by surgical decompression because of the increased incidence of problems which arise, including the necessity for prolonged observation.

2460 Coral Way.

Medical Research at the University of Florida

July 1, 1961-June 30, 1962

The College of Medicine at the University of Florida has continued to pursue research in all departments. The program has shown healthy growth during the 1961-1962 fiscal year. The research program is expected now to slow its rate of growth and to plateau at about the current level for the next few years. The limiting factor for growth of the research program is availability of laboratory space and associated faculty offices.

PHILOSOPHY OF RESEARCH.—A medical school has as its major responsibility teaching of students at many levels. A second major responsibility is the addition of new knowledge in the general field of biology as it applies to medicine. A third responsibility is service to people of the state, chiefly in the form of patient care. All three of these objectives are interrelated and in our school revolve around the teaching program. Many research projects are at basic fundamental levels in which the findings may have no immediate application to patient care. Almost all clinical research can be applied to the care of patients as new techniques and instruments are developed. Other clinical research projects evaluate current practices and serve as a retrospective critique of present methods of diagnosis and treatment.

Research in our school is used as an educational tool. We are interested in the development of a pattern of thinking in the student at whatever stage of his professional development he may be. Whether the student is pointing toward the practice of medicine or a research career, he must learn to recognize unsolved problems, review the present state of knowledge, plan for the collection of new data by the best techniques, analyze the data and estimate the errors inherent in their collection, and draw a conclusion. Research offers

an ideal method for training of the mind in thinking by the scientific method.

At faculty level, research keeps the individual intellectually stimulated and improves the quality of teaching. Almost every faculty member has at least one research project in progress. A steadily increasing level of research training is that at postdoctorate level for both holders of the M.D. and Ph.D. degrees. Research training at this level is intended to provide background and skills for the conduct of future research in an academic or industrial setting, and to develop future faculty for the new medical schools being formed, as well as to replenish the faculty of existing schools. Research training is in progress both in clinical departments and in those devoted to the basic medical sciences; some programs are carried out conjointly by several departments.

House officers in many clinical departments spend a portion of a year in research as part of their training. Medical students in this school all participate in research through the second year course in Experimental Medicine. Medical students may elect to participate in ongoing research projects throughout the entire curriculum. The research may be done as an elective or as extra work which can be applied toward graduation with honors. Graduate students for Masters and Ph.D. degrees in the medical sciences all conduct original research as the basis for their thesis requirement. In order to introduce students to this pattern of thinking as early as possible, a few selected undergraduate liberal arts college students and high school students are permitted to work in research laboratories of faculty members, chiefly during the summers.

The rapid growth of research has had a tremendous impact nationwide on medical education. This impact has been extensively explored through a Teaching Institute conducted by the Association of American Medical Colleges.¹

FACILITIES.—A small medical research wing was completed in October 1961. The central animal quarters were expanded modestly, and a number of new laboratories were made available. Small additions have been made to the Animal Farm located two miles west of the Medical Sciences Building. This farm was planned as an animal storage facility for long term experiments. and breeding and quarantine of newly received animals. The complete utilization of the Medical Sciences Building has forced us to plan for inclusion of laboratory facilities in future additions to the farm. Continuous small scale remodeling is underway in the Medical Sciences Building and Teaching Hospital to increase the efficiency of existing space for research. Laboratories have been constructed even in pipe space at the lowest level of the building which had been intended only for dead storage. The new laboratory for Pediatric Cardiology in the basement of the Teaching Hospital will complement the recently completed new Cardiac Catheterization Laboratory for patients located between the operating suite and Radiology.

Grants received, but not included in this report, will permit in the next fiscal year remodeling for a Clinical Research Center of a portion of the sixth floor of the Teaching Hospital; an electrical instrument maintenance and repair shop; and the construction of a primate research facility on the farm with cages for the animals and associated research laboratories.

Equipment.—Major pieces of equipment continue to be added with research funds. The first small computers have been installed to permit the exploration of mathematical models of biologic problems. An example is the application of this technique to the study of isotopes in thyroid metabolism. Gas chromatography is now available to all departments. Equipment of various types for graduate programs in Biophysics has been installed.

SUPPORT.—Several institutional grants for general support of research have been received. The first was made by the American Cancer Society to promote the preliminary exploration of

new ideas at pilot level. The National Institutes of Health have given a similar grant which will permit the establishment of supporting facilities as well as the support of preliminary experiments and small research projects. These grants should be looked on as "risk capital" to support "flyers," as well as for support of more conventional projects.

A grant for support of beds in the Teaching Hospital has been awarded by the National Foundation for a special Birth Defects Center.

Support of medical students through small research fellowships has been made possible by a number of voluntary health agencies in Florida as well as by a special grant from the National Institutes of Health.

Budgeted state funds have been used for small pieces of equipment and for supplies, chiefly for preliminary exploration of ideas on which subsequent full research project grant applications may be based. No state support of research beds is available.

FACULTY.—Several faculty members have spent a year abroad for advanced research training, including one member each in France and Italy. Several faculty members have received specific recognition of academic potential, including research, through the awarding of a Markle Scholarship or Career Development Award by the Public Health Service. Several voluntary agencies in Florida have partially supported junior faculty members so that they may devote more time to research and teaching.

New Programs.—A Division of Otolaryngology was activated. A major research effort will involve the middle ear and temporal bone. A Division of Ophthalmology has been established; a major research effort will be on the application of chemotherapeutic agents which block the formation of nucleic acids to the treatment of viral infections.

New programs in the fields of Anatomy and Pathology are utilizing marine forms obtained from the University research facility at Sea Horse Key.

LEVEL OF SUPPORT.—During the period July 1, 1961, to June 30, 1962, 86 research grants were active in the College of Medicine with a face value of \$1,793,951. During this same fiscal year, 40 training grants with a face value of \$780,330 have been in effect. These figures do not include support of faculty through research fellowships

J. H. Comroe Jr., ed. Research and Medical Education. Report of the Ninth Teaching Institute, Association of American Medical Colleges. Colorado Springs, Colorado, December 3-7, 1961. J. Med. Education 37:1-279, Part 2 (Dec.) 1962

awarded to individuals directly. The figures do not include state support which is intimately intertwined with the educational program.

The following reports are arranged by departments according to the senior author. Selected papers have been abstracted and the reference to the original publication has been included. No attempt has been made to review the complete bibliography of 173 papers; purely clinical ones and case reports which present no research data have not been included. Many of the authors are medical or graduate students who have participated in research as part of their training.

Anatomy

A major long range research program on the production of congenital defects in experimental animals by a variety of methods has continued. The pattern of malformations produced by synergistic action of the minimal doses necessary to induce malformations by excessive administration of vitamin A and of trypan blue differed appreciably from that produced by either agent acting singly. Exencephaly was the most common malformation when both agents were employed simultaneously, but ranked second with hypervitaminosis A alone and third in the administration of trypan blue to rats. A purified pteroylglutamic acid deficient diet, which also contained an antimetabolite against this vitamin, was fed for 36 hours beginning on the eighth day of gestation in rats. Mitotic activity was reduced and the neural tube of the deficient embryos was open anteriorly by the tenth day. A striking reduction in both acid and alkaline phosphatase was detected by the tenth day. Phosphatase activity was also reduced by the injection of trypan blue in the pregnant rat. Pregnant rats were injected with radioactive phosphorus. The specific activity of the placenta reached a peak within two hours and that of the embryo after six hours. The DNA specific activity increased exponentially with increasing time of exposure, indicating the rate of synthesis was consistent with studies on regenerating rat liver. The exposure of fertilized eggs of sea urchins to Aminopterin, a folic acid inhibitor, produced effects which are both dosage and time dependent. The embryos are most sensitive during cleavage stages. This study confirms in a marine form the production of experimental abnormalities found by the same technique in mammalian embryonic systems.

Wilson, J. G.: Teratogenic Interaction of Minimal Doses of Hypervitaminosis A and Trypan Blue in the Rat, Anat. Rec. 142:292 (Feb.) 1962.

Johnson, E. M.: Relationship of Phosphatase Activity to Teratogenesis in the Rat, Anat. Rec. 142:244 (Mar.) 1962. (abst.)

Skalko, R. G.: Isotopic Studies on DNA Synthesis in the Rat Embryo, Anat. Rec. 142:280 (Mar.) 1962. (abst.)

Skalko, R. G.: Aminopterin Effects on Arbacia Punctulata Development, Biol. Bull. 121:378 (Oct.) 1961.

Another group has conducted studies on the bite of rattlesnakes and pit vipers, utilizing venom labeled with radioactive iodine. Percutaneous incision and suction at the points of venom injection, when promptly done, effect the removal of as much as 50 per cent of the venom dose in a subcutaneous bite within 15 minutes even when no tourniquet is employed. Antivenin should be given within 30 minutes both by intravenous and intramuscular routes. As much as 86 per cent of the injected dose may accumulate at the site of the bite within two hours. The application of cold inhibits the access of the antivenin to the bite area and cold is recommended only to relieve the pain of the bite. Corticosteroids are not effective in the immediate treatment and may inhibit antibody neutralization of the venom. The administration of drugs containing sulfhydryl groups prolongs the survival times of mice injected with Asiatic viper venom. Glutathione is more protective than cysteine, and females are more readily protected than male animals. Specific inhibition of Phospholipase A activity can be demonstrated in vitro. The mechanism of this protection is apparently the chelation of necessary coenzymes in the venon-protein complex.

The octopus poison apparatus consists of two pairs of salivary glands. Tracer doses of radio-active iodine added to sea water result in the accumulation of the isotope in these glands and prior treatment with thyroid-stimulating hormone results in increased storage by the anterior gland.

Gennaro, J. F. Jr.: A Review of the Treatment of Snake Bite, Symposium on Venomous and Poisonous Animals and Noxious Plants (B) Snakes, Tenth Pacific Science Congress (Aug.) 1961. (abst.)

Gennaro, J. F. Jr., and McCollough, N.: Comments on Contemporary Treatment of Poisonous Snake Bite in North America, Med. Rec. and Annls. 34:224-225 (Aug.) 1961.

Gennaro, J. F. Jr.; Brewster, H. B., and Yahnke, S. J.: Structures and Observations on the

Function of the Poison Apparatus of the Octopus, Anat. Rec. 142:234 (Feb.) 1962. (abst.)

Another group has continued its studies on the effect of discrete cortical lesions in the cerebellum of alligators. Lesions in the medial two thirds of the cerebellum resulted in postural effects associated with general reduction in the level of muscle tonus and impairment of proprioceptive placing.

Goodman, D. C., and Steinfeld, L. A.: Cerebellar Function in the Alligator (Caiman Sklerops), Anat. Rec. 142:307 (Feb.) 1962. (abst.)

Biochemistry

Continuation of the studies on normal and abnormal globulins shows that those in multiple myeloma and macroglobulinemia are immunologically related and chemically similar to normal human gamma globulin, but differ in physical properties, N terminal groups, and antigenic determinants. Bence-Jones proteins are of two major antigenic types, neither of which contains determinants analogous to those in papain-digested fractions of normal gamma globulin. The sensitive bond involved in papain cleavage, in general, involves a branched chain amino acid, usually leucine.

Putnam, F. W.; Migita, S., and Easley, C. W.: Comparative Structural Studies of Abnormal Globulins, Federation Proc. 21:77 (Mar.-Apr.) 1962.

Putnam, F. W.; Easley, C. W., and Lynn, L. T.: Site of Cleavage of γ-Globulins by Papain, Biochim. et biophys. acta 58:279-290 (Apr.) 1962.

Another group has continued its studies on the relationship of carotenoids in relation to vitamin A metabolism. Cholic acid derivatives were most effective in stimulating the over-all conversion of beta carotene into vitamin A after absorption from the intestine. Retinene labeled with radioactive carbon appears in the liver of rats as vitamin A ester. The liver enzyme acting on retinene was found to be the same as that acting on ethyl alcohol.

Olson, J. A.: The Absorption of Beta-Carotene and Its Conversion into Vitamin A, Am. J. Clin. Nutrition 9:1-12 (July-Aug.) 1961.

Zachman, R. D., and Olson, J. A.: A Comparison of Retinene Reductase and Alcohol Dehydrogenase of Rat Liver, J. Biol. Chem. 236:2309-2313 (Aug.) 1961.

A method for determination of inorganic sulfate in urine and other biological samples by a

colorimetric method using excess barium chloranilate was developed.

Wainer, A. and Koch, A. L.: Determination of Inorganic Sulfate in Urine Using Barium Chloranilate, Anal. Biochem. 3:457-461 (June) 1962.

The quantitatively studied urinary mucopolysaccharide excretion of a family with the sexlinked form of gargoylism indicates that neither carriers nor unaffected siblings excrete significantly higher than normal quantities of total acid mucopolysaccharide.

Campbell, T. N., and Fried, M.: Urinary Mucopolysaccharide Excretion in the Sex-Linked Form of the Hurler Syndrome, Proc. Soc. Exper. Biol. & Med. 108:529-533 (Nov.) 1961.

Medicine

Studies on neuronal discharge phenomena in the epileptic process continue. Microelectrode studies of single neurons in the epileptogenic focus of monkeys indicate that the activity is characterized by high frequency bursts of discharge. Microelectrode recording of the activity of single cells in the cortex of unanesthetized human beings would be expected to show similar differences between the spontaneous activity of cells of the normal cortex and those in the epileptogenic focus. The relatively enduring dendritic depolarization is a basic property of epileptic neurons and may be a consequence of mechanical distortion by the cortical scar.

Ward, A. A. Jr., and Schmidt, R. P.: Some Properties of Single Epileptic Neurons, Arch. Neurol. 5:308-313 (Sept.) 1961.

Intracardiac phonocardiography and pressure tracings were recorded simultaneously from the atrium and ventricle of open chest dogs and from human subjects at open heart surgery. The third sound occurs during early rapid diastolic ventricular filling at a time when atrial pressure exceeds ventricular pressure. The fourth sound is demonstrated to consist of two components, both occurring when atrial pressure exceeds ventricular pressure.

Crevasse, L.; Wheat, M. W.; Wilson, J. R.; Leeds, R. F., and Taylor, W. J.: The Mechanism of the Generation of the Third and Fourth Heart Sounds, Circulation 24:635-642 (Apr.) 1962.

The fundamental studies on the metabolism of heart muscle have been continued. Human cardiac tissue slices, obtained at open heart surgery, were incubated under varying conditions in a Warburg apparatus. Lanatoside C has a direct effect in markedly increasing oxygen utilization and is dependent on the presence of calcium. Several studies on isolated rat heart perfusion in a closed system suggest that palmitate, acetate and pyruvate are oxidized by the heart in preference to glucose and that the control for substrate oxidation is at the pyruvate-acetyl-CoA level.

Crevasse, L., and Wheat, M. W.: Role of Calcium and Lanatoside-C in Oxygen Consumption in Human Myocardial Tissue Slices, Circulation 24:911, Part 2 (Oct.) 1961. (abst.)

Shipp, J. C.; Opie, L., and Evans, J.: Effect of Acetate and Pyruvate on Metabolism of Glucose U-C¹⁴ and Palmitate-1-C¹⁴ in Isolated Perfused Rat Heart, J. Clin. Invest. 41:1401 (June) 1962.

Hypercalcemia was found in hypothyroid human patients and rats. Studies with radioactive calcium indicate an impaired rate of disposition of absorbed calcium with resulting hypercalcemia. An adult patient with myxedema and hypercalcemia became normocalcemic when rendered euthyroid.

Lowe, C. E.; Bird, E. D., and Thomas, W. C. Jr.: Hypercalcemia in Myxedema, J. Clin. Endocrinol. 22:261-267 (Mar.) 1962.

In a patient receiving anticoagulant therapy with heparin sudden nonpleuritic flank pain developed and was interpreted as due to bilateral adrenal hemorrhage. Urinary studies revealed a marked decrease in 17-ketosteroid and hydroxysteroid levels associated with hyperkalemia and hyponatremia. Cortisone and desoxycorticosterone acetate-ester were required to control the adrenal insufficiency.

Harper, J. R.; Ginn, W. M., and Taylor, W. J.: Bilateral Adrenal Hemorrhage—A Complication of Anticoagulent Therapy, Am. J. Med. 32 (8); 984-988 (June) 1962.

Rats on a diet deficient in magnesium show a significant increase in aldosterone secretion. Other studies on normal and adrenalectomized human beings and dogs have shown that the activity of distal tubular ion exchange processes involving sodium load and potassium excretion is related to the dose of administered mineralocorticoid.

Ginn, H. E., and Cade, R.: Aldosterone Secretion in Magnesium Deficient Rats, The Physiologist 4 (8): 40 (Aug.) 1961.

Cade, R., and Shalhoub, R.: The Effect of Mineralocorticoids on Renal Handling of Potassium, J. Clin. Invest. 40:1028 (June) 1961.

Studies on the lipid lowering effect of sulfonylurea in patients with minimal abnormality of glucose metabolism suggest that changes in blood lipids may overshadow or precede change in glucose metabolism in the diabetic.

Munroe, J., and Shipp, J. C.: Effect of Sulfonylurea Compounds on Hyperlipemia and Hypercholesterolemia in the Diabetic, Clin. Res. 10: 88 (Jan.) 1962. (abst.)

Studies by the hematology group on the exchange of human hemoglobin bound to haptoglobin with hemoglobin free in solution show that the haptoglobin-hemoglobin bond is fairly stable. In 15 patients with refractory anemia the concentration of circulating erythropoietin was elevated, roughly related to the degree of anemia, and generally 10 to 40 times that normally seen. The lack of correlation between concentration and marrow cellularity localizes the defect to the marrow and would indicate exogenous erythropoietin administration would have no beneficial effect. Increased circulating erythropoietin was not found in eight patients with polycythemia vera, indicating that this disease is a myeloproliferative disorder beyond the bounds of normal regulation. A patient with drug-induced aplastic anemia recovered after transfusion of bone marrow obtained from an identical twin.

An animal model for sickling of red blood cells has been found in white-tailed deer trapped in Florida. The cells tend to sickle in the presence of high pH and complete oxygenation. An abnormal hemoglobin was separated by electrophoresis.

Noyes, W. D., and Laurell, C. B.: The In Vitro Stability of the Haptoglobin - Hemoglobin Complex, Scandinavian J. Clin. and Lab. Invest. 13:625-627 (Dec.) 1961.

Noyes, W. D.; Domm, B. M., and Willis, L. C.: Erythropoietin Assay in Refractory Anemia and Polycythemia, Clin. Res. 10:27 (Jan.) 1962. (abst.)

Robins, M. M., and Noyes, W. D.: Aplastic Anemia Treated with Bone-Marrow Transfusion from an Identical Twin, New Eng. J. Med. 265:-974-979 (Nov.) 1961.

Taylor, W. J.; Childress, R. C., and Kitchen, H.: The Production and Behavior of Sickled Erythrocytes in Deer Blood, Clin. Res. 10:208 (Apr.) 1962.

Microbiology

Studies on the hyperreactivity to endotoxin developing during infection suggests that events

apparently unrelated to the infection in time may influence decisively the manifestations of disease. Mice infected with BCG were studied following the injection of lipopolysaccharide derived from Salmonella.

Suter, E., and Kirsanow, E. M.: Hyperreactivity to Endotoxin in Mice Infected with Mycobacteria. Induction and Elicitation of the Reactions, Immunology 4:354-365 (Oct.) 1961.

Suter, E.: Hyperreactivity to Endotoxin in Infection, Trans. N. Y. Acad. Sci. 24:281-290 (Jan.) 1962.

A new group is engaged in fundamental studies of antigen-antibody complexes. Studies in rabbits injected with bovine serum albumin indicate that the antibody-antigen complex consists of a single antigen molecule bound to several antibody fragments equal in number to the "valence" of the antigen.

Cebra, J. J.; Givol, D., and Katchalski, E.: Soluble Complexes of Antigen and Antibody Fragments, J. Biol. Chem. 237:751-759 (Mar.) 1962.

Studies on the growth of bacterial cells in a variety of media show insensitivity of cell division and DNA synthesis. Synthesis of RNA is extremely sensitive to environmental change. In nutritional deprivation, synthesis slows down, but is resumed rapidly on restoration of growth. The cellular changes seen may be attributable to this high degree of irritability of RNA metabolism.

Schaechter, M.: Patterns of Cellular Control During Unbalanced Growth, Cold Spring Harbor Symposia on Quantitative Biology 26:53-62, 1961.

Studies in mice on immunity to infection by schistosomes have continued. The number of immunizing exposures and the size of the challenge dose were not important, but a period of 60 days was required before increased resistance was apparent.

Hunter, G. W. III; Crandall, R. B.; Zickafoose, D. E., and Purvis, Q. B.: Studies on Schistosomiasis. XVIII. Some Factors Affecting Resistance to *Schistosoma mansoni* Infections in Albino Mice, Am. J. Trop. Med. & Hyg. 11 (5): 17-24 (Jan.) 1962.

A case of infestation of a child in Florida with a double-pored dog tapeworm has been reported. Pet dogs and cats in the households of patients infected should be checked for the presence of the parasite.

Hunter, G. W. III, and Slotnick, I. J.: Further Records of Dipylidiasis in Children in the

United States, Am. J. Trop. Med. & Hyg. 11:365 (May) 1962.

Normal and immune monocytes from guinea pigs immunized with BCG are inhibitory for the growth of tubercle bacilli. The active principle is not lysozyme. Rabbit mononuclear cells phagocytize mycobacteria maximally at a pH of 7.5, but to an appreciable extent between the range of 5.85 and 8.85.

Ramseier, H., and Suter, E.: An Antimyco-bacterial Principle from Monocytes of Normal and Immunized Guinea Pigs, Bact. Proc., p. 72, 1962.

Tucker, D. N.; Hill, W. C., and Gifford, G. E.: The Effect of pH on Phagocytosis by Rabbit Mononuclear Cells, Bact. Proc., p. 79, 1962.

Obstetrics and Gynecology

Studies on the transport of materials across the placenta have been continued. In the human patient at term, studies have been made on total osmotic pressure of maternal plasma and amniotic fluid as well as fetal plasma. An osmotic gradient is established across the placenta following the infusion of mannitol, with water moving more rapidly than sodium. The average oxygen pressure gradient between maternal and fetal blood is 30 millimeters of mercury in cases of abnormal pregnancy in which oxygen is administered, and is 3.5 millimeters of mercury in similar cases in which oxygen is not administered. Studies on pregnant goats indicate no net anaerobic metabolism by the pregnant uterus as a whole when lactate and pyruvate are measured. The oxygen tension in the umbilical vessels of pregnant ewes at high altitude was found to be the same as that for fetuses carried by ewes at sea level.

Prystowsky, H.: Prenatal Pediatrics, Postgrad. Med. 31:284-290 (Mar.) 1962.

Huckabee, W. E.; Metcalfe, J.; Prystowsky, H., and Barron, D. H.: Movements of Lactate and Pyruvate in Pregnant Uterus, American J. Physiology 202:193-197 (Jan.) 1962.

Huckabee, W. E.; Metcalfe, J.; Prystowsky, H., and Barron, D. H.: Insufficiency of O₂ Supply to Pregnant Uterus, American J. Physiology 202:198-204 (Jan.) 1962.

Metcalfe, J.; Meschia, G.; Hellegers, A.; Prystowsky, H.; Huckabee, W., and Barron, D. H.: Observations on the Placental Exchange of the Respiratory Gases in Pregnant Ewes at High Altitude, Quarterly J. Experimental Physiology 47:74-92 (Jan.) 1962.

The alkali reserve in human pregnancy has been found to be lowered.

Prystowsky, H.; Hellegers, A. E., and Bruns, P. D.: A Comparative Study of the Alkali Reserve of Normal and Pregnant Women, Am. J. Obst. and Gynec. 82:1295-1301 (Dec.) 1961.

Human maternal serum isocitric dehydrogenase was normal during all stages of pregnancy. Cord serum had significantly higher values than maternal serum. Elevated values were found in severe pre-eclampsia, abruptio placentae, infected abortion and tubal pregnancy. A reduction in placental levels was found in the presence of infarction.

Little, W. A., and Kirpalani, G.: Isocitric Dehydrogenase in Pregnancy, Am. J. Obst. and Gynec. 83:1346-1351 (May) 1962.

Another group, studying the microbiology of the female genital tract, has found 12 per cent bacteriuria in the immediate puerperium whether or not the patient was catheterized prior to delivery. Bacteriuria was increased in patients catheterized at delivery and post-partum. Only one instance of an increase in residual urine volume was found in 100 subjects on whom catheterization was omitted. Routine catheterization of the urinary bladder at delivery is not indicated. Bacteriuria is greatly increased when an indwelling catheter is used.

Slotnick, I. J., and Prystowsky, H.: Microbiology of the Female Genital Tract, I. The Infectious Hazard of Prophylactic Catheterization of the Urinary Bladder Prior to Delivery, Am. J. Obst. and Gynec. 83:1102-1111 (Apr.) 1962.

Hildebrandt, R. J.; Slotnick, I. J., and Prystowsky, H.: The Relationship Between Acquired Bacteriuria, the Foley and Robinson Catheters, and Mycitracin Ointment, Surg., Gynec., & Obstet. 114:341-344 (Mar.) 1962.

Studies on glucose-6-phosphate dehydrogenase metabolism in the cow and rat indicate that estrogen and thyroid hormones inhibit the formation of adrenocorticoids by inhibiting activity of the enzyme. Tropic hormones stimulate the pentose-phosphate pathway in tissues such as fat and liver.

McKerns, K. W.: A Biochemical Site of Action of Estrogens and Thyroid Hormones in the Regulation of Metabolism, Abstracts of the Fifth Pan American Congress of Endocrinology, (Oct.) 1961.

Pathology

Cardiac and cerebral lesions identical with those occurring in fatal human cases of trichinosis have been induced by experimental infection in rabbits. The lesions are more likely related to the toxic effects of larval metabolites than to the formation of antilarval antibodies and subsequent antigen-antibody reaction in the tissues.

Edwards, J. L., and Hood, C. I.: Studies on the Pathogenesis of Cardiac and Cerebral Lesions of Experimental Trichinosis in Rabbits, Am. J. Path. 40 (8):711-720 (June) 1962.

Hemorrhages were found in most organs and tissues in 33 cases of proved human leptospirosis. Hepatic lesions depended in severity upon the duration of the illness. Renal insufficiency was primarily the result of tubular damage. Extension of these studies into experimental infections in young guinea pigs showed decrease in serum alkaline phosphatase activity as well as in kidney homogenate, though no change was noted in the liver. Serum glutamic-oxaloacetic transaminase rose above normal coincident with the demonstration of liver cell necrosis. The hemorrhage is due to damage of capillary walls by an undetermined toxin.

Arean, V. M.: The Pathologic Anatomy and Pathogenesis of Fatal Human Leptospirosis (Weil's Disease), Am. J. Path. 40 (8):393-423 (Apr.) 1962.

Arean, V. M.: Studies on the Pathogenesis of Leptospirosis, Lab. Investigation 11 (8):273-288 (Apr.) 1962.

A study of 300 aortas obtained at autopsy on patients in Puerto Rico showed that, after age 4, all patients had some degree of early atherosclerosis. In the first decade of life the intimal surface involvement by fibrous plaques was greater in the white patient than in the Negro.

Galindo, L.; Arean, V. M.; Strong, J. P., and Baldizon, C.: Atherosclerosis in Puerto Rico, Study of Early Aortic Lesions, A.M.A. Arch. of Pathol. 72:367-374 (Sept.) 1961.

The use of data obtained from clinical specimens is recommended to supplement and complement other methods of quality control employing standard and reference samples in a routine hospital laboratory.

Hoffman, R. G.; Waid, M. E., and Henry, J. B.: Clinical Specimens and Reference Samples for the Quality Control of Laboratory Accuracy, Am. J. M. Technol. 27 (8):309-417 (Nov.Dec.) 1961.

Severe pancreatic glandular atrophy, chronic pancreatitis and fat necrosis were found at autopsy in a boy with severe congestive heart failure treated with hydrochlorothiazide for a period of 285 days.

Shanklin, D. R.: Pancreatic Atrophy Apparently Secondary to Hydrochlorothiazide, New Eng. J. Med. 266:1097-1099 (May) 1962.

Pediatrics

Long term immunologic studies have been further extended. In newborn rabbits, immunologic tolerance could be induced after quantitative absorption of heterologous protein through the gut. Indirect evidence suggests that the antigen significant to the tolerant state is located intracellularly.

Smith, R. T.: Immunological Tolerance of Nonliving Antigens, Immunol. Vol. 1, p. 67-124 Acad. Press, Inc., N. Y., 1961.

Bellanti, J. A.: Eitzman, D. V., and Smith, R. T.: Sequence of Antibody Component Appearance in Newborn Rabbits, Fed. Proc. 21 (8):30 (Mar.-Apr.) 1962. (abst.)

The urine of male and female lion cubs with dwarf stature and skeletal abnormalities has been studied. Excessive acid mucopolysaccharide excretion was demonstrated in the urine. The amount of acid mucopolysaccharide in the liver of one of the animals was relatively small in comparison with the glycogen-like polysaccharide.

A new enzyme which desulfurates thiourea has been found in the thyroid, saliva and posterior tongue—the area in the human being where taste buds are located. The enzyme has been found in several species and has been isolated from human saliva. These studies may have significance in attempting to explain on a biochemical basis the connection between inability to taste phenylthiocarbamide and congenital athyrotic cretinism.

Lorincz, A. E.; Enneking, W. F., and Fry, R. M.: Dwarfism in Lion Cubs—An Heritable Disorder with Mucopolysaccariduria and Skeletal Malformation, Soc. for Ped. Research, Atlantic City, N. J., (May) 1962. (abst.)

Shepard, T. H.; Lorincz, A. E., and Gartler, S.: Enzymatic Desulfuration of Thiourea by Saliva, Tongue and Thyroid, Soc. for Ped. Research, Atlantic City, N. J., (May) 1962. (abst.)

Study of six infants with patent ductus arteriosus showed a wide spectrum of findings on auscultation and electrocardiographic and roentgenologic examination.

An infant with aortic atresia was studied by

electrocardiographic and phonocardiographic techniques as well as cardiac catheterization.

Studies of cardiac output, central arterial and venous pressures, and circulation times in dogs subjected to thoracotomy and surgically induced complete atrioventricular dissociation indicate that thoracotomy per se must be considered when evaluating data concerning the hemodynamic consequences of atrioventricular dissociation.

Cruze, K.; Elliott, L. P.; Schiebler, G. L., and Wheat, M. W., Jr.: Unusual Manifestations of the Infant Patent Ductus Arteriosus, Circulation 24:912, Part 2 (Oct.) 1961. (abst.)

Elliott, L. P.; Best, E. B., and Schiebler, G. L.: Aortic Atresia—A Case Report and a Review, Am. Heart J. 62:821-829 (Dec.) 1961.

Schiebler, G. L., and Cruze, K.: Hemodynamic Effects of Thoracotomy in Dogs with and without Complete Atrioventricular Dissociation, Soc. for Ped. Res., Atlantic City, N. J., p. 62 (May) 1962.

Neurologic manifestations were found in 18 per cent of patients with abnormal hemoglobin in the circulating blood. The incidence of neurologic abnormalities was highest with Hgb SS, slightly less with Hgb SC and lowest with Hgb AS. Only cerebral infarction can be clearly attributed to the abnormal hemoglobin found in the sickling phenomenon.

Obstructive hydrocephalus was created in adult dogs by the intracisternal injection of kaolin. The gray matter remained normal while the volume of the periventricular white matter was reduced. Loss of lipid and protein fractions and a secondary increase in water, sodium and chloride content were noted. Light and electron microscopy provided no morphologic explanation for these changes.

Greer, M., and Schotland, D.: Abnormal Hemoglobin as a Cause of Neurological Disease, Neurology 12 (8):114-123 (Feb.) 1962.

Greer, M., and Fishman, R. A.: Effects of Experimental Obstructive Hydrocephalus Upon the Cerebrum, Transactions of the American Neurological Association 86:23-27, 1961.

Pharmacology and Therapeutics

Long term studies on carbonic anhydrase have been continued. Carbonic anhydrase in the dogfish was found to be absent in the lens and kidney where the enzyme occurs in high concentration in mammals. Administration of an inhibitor, acetazolamide, resulted in extreme respiratory acidosis in plasma, abolition of the normal chloride excess in cerebrospinal fluid, and lowering of the bicar-

bonate in aqueous humor. These changes also have been observed in certain mammals.

Single cell analyses of carbonic anhydrase demonstrate that this enzyme is selectively concentrated in the glial and choroid cells of the rat brain. This specific localization implies the active transport of chloride from the capillaries to the interstitial and cerebrospinal fluids.

Maren, T. H.: Ionic Composition of Cerebrospinal Fluid and Aqueous Humor of the Dogfish Squalus Acanthias-II. Carbonic Anhydrase Activity and Inhibition, Comp. Biochem. Physiol. 5:201-215 (Mar.) 1962.

Giacobini, E.: Localization of Carbonic Anhydrase in the Nervous System, Science 134:1524-1525 (Nov.) 1961.

A series of experiments in dogs with Heidenhain pouches showed that the administration of a carbonic anhydrase inhibitor, acetazolamide, reduced the acid secretion for two to four hours. Intravenous administration of hydrochloric acid initially suppressed but later augmented gastric acidity, and acetazolamide had no suppressive effect. Intravenous sodium bicarbonate reduced the gastric acidity in dogs made acidotic by acetazolamide.

Byers, F. M.; Jordan, P. H., and Maren, T. H.: Effects of Acetazolamide and Metabolic Acidosis and Alkalosis Upon Gastric Acid Secretion, Am. J. of Physiology 202:429-436 (Mar.) 1962.

The binding of sulfonamides to plasma protein can be influenced by the administration of a displacing agent which interferes with the binding action. Binding alters both the in vitro and in vivo activity of the drugs in the rat.

Dog liver slices hydrolized acetylsulfanilamide more rapidly than did rabbit liver slices, but did not acetylate sulfanilamide under conditions where acetylation was catalyzed by rabbit liver slices or pigeon liver homogenates. The inhibitor was thermolabile, nondialyzable, and deactivated by protein precipitants, but remained active on lyophilization.

Anton, A. H.: A Drug-induced Change in the Distribution and Renal Excretion of Sulfonamides, J. Pharm. and Expt. Therap. 134:291-303 (Dec.) 1961.

Leibman, K. C., and Anaclerio, A. M.: Comparative Studies on Sulphanilamide Acetylation; an Inhibitor in Dog Liver, Biochem. Pharm. 8:47 (Aug.) 1961.

Studies on the diuresis induced in chickens by the intravenous administration of aminophylline suggest a tubular point of attack. Pretreatment with probenecid, however, did not affect the diuretic response. Reserpine greatly reduced the diuretic effect of hydrochlorothiazide. The reserpine effect on diuretic activity does not seem to be due to reduced glomerular filtration rate, since the action of a mercurial diuretic was ineffective.

Nechay, B. R., and Sanner, E.: Theophylline Diuresis in the Chicken, Acta pharmacol. et toxicol. 18:329-338 (Dec.) 1961.

Nechay, B. R., and Sanner, E.: Interference of Reserpine with the Diuretic Action of Theophylline and Hydrochlorothiazide on the Chicken, Acta pharmacol. et toxicol. 18:339-350 (Dec.) 1961.

Physiology

Fundamental studies on the action of neuromuscular cells have been continued. In single nerve fibers from a frog, two carrier systems in the membrane are postulated—one specific to sodium, the other to potassium. The potassium system is more slowly activated than the sodium one. Each system possesses quite different, independent characteristics. Studies on a single motor axon from the lobster have shown that a slow, prolonged depolarization, elicited by adequate cathodal stimuli, is a response to activity of the potassium carrier system.

Ooyama, H., and Wright, E. B.: Activity of Potassium Mechanism in the Single Ranvier Node During Excitation, J. Neurophysiol. 25(8):67-93 (Jan.) 1962.

Wright, E. B., and Tomita, T.: Separation of the Sodium and Potassium Ion Carrier System in Crustacean Motor Axon, Am. J. Physiol. 202(8): 856-864 (May) 1962.

Studies on the action potential of single cardiac muscle fibers from the auricle of the frog suggest that two depolarizations are involved in a contraction. The evidence supports the idea that two ion carrier systems exist in the excitable membrane, one of which reacts rapidly and the other more slowly. The slow system appears to react with sodium and causes prolonged depolarization or plateau. Recovery is probably due to slow inactivation of this process.

Wright, E. B., and Ogata, M.: Action Potential of Amphibian Single Auricular Muscle Fiber: A Dual Response, Am. J. Physiol. 201(6):1101-1108 (Dec.) 1961.

A series of studies on hypertension in the rat is being carried out. Regulation of sodium intake

by rats suggests that sodium content in the diet does not influence intake by hypertensive rats which are able to detect only the sodium in solution.

The administration of chlorothiazide to rats made hypertensive by bilateral encapsulation of the kidneys with latex envelopes reduced the level to which the blood pressure rose when compared with untreated controls. The drugs increased the rate of release of radioactive iodine from the thyroid gland. The administration of antithyroid drugs of the thiouracil series is accompanied by an increase in the intake of sodium chloride which appears to be independent of either pituitary or adrenal glandular control. The thyroid gland is thought to play an important secondary role in the development of renal hypertension. Thyroid activity increases as the systolic blood pressure approaches 150 millimeters. As systolic blood pressure exceeds 150 millimeters, the organ-to-bodyweight ratios of heart, thyroid, adrenals and kidnevs increase. Intact or hypophysectomized rats when treated with antithyroid drugs of the thiouracil series increased the water intake and urinary output. The animals showed a decreased urinary concentrating ability to Pitressin administration after dehydration.

Fregly, M. J.: Regulation of Sodium Chloride Intake by Normotensive and Hypertensive Rats, Am. J. Cardiology 8:870-879 (Dec.) 1961.

Fregly, M. J.: Effect of Chlorothiazide and Hydrochlorothiazide on Blood Pressure and Thyroid Activity of Hypertensive Rats, Am. J. Cardiology 8:890-898 (Dec.) 1961.

Fregly, M. J.: Galindo, O., and Cook, K. M.: Spontaneous Sodium Chloride Appetite of Goitrogen-treated Rats: Effect of Hypophysectomy and Adrenalectomy, Endocrinology 69(8):1060-1067 (Dec.) 1961.

Fregly, M. J., and Gonzalez, J.: Activity of Thyroid Gland During Development of Renal Hypertension in Rats, Am. J. Cardiology 8(8):694-699 (Nov.) 1961.

Fregly, M. J.: Relationship Between Blood Pressure and Organ Weight in the Rat, Am. J. Physiol. 202(8):967-970 (May) 1962.

Fregly, M. J.: Increased Water Exchange in Rats Treated with Antithyroid Drugs, J. Pharm. Exptl. Therap. 134(8):69-76 (Oct.) 1961.

Rats were treated with propylthiouracil and the effect on spontaneous running activity at various air temperatures was studied. The regulation of body temperature in cold air by adjustment of activity level is an important aspect of the total regulatory mechanism. Hypothyroidism alters the relationship between body temperature and activity level. Daily intraperitoneal injections of reserpine lowered the body temperature of rats maintained at room temperature. Metabolic studies indicate that the mechanism involved was decrease in heat production rather than increase in heat loss. Thyroxin improved the metabolic response of reserpine-treated rats to cold, but the administration of thyroid-stimulating hormone did not improve the response. Reserpine may interfere with the normal response of the thyroid gland to stimulation by pituitary hormone, but peripheral utilization of the thyroid hormone was not impaired.

Fregly, M. J.: Effect of Changes of Ambient Temperature on Spontaneous Activity of Hypothyroid Rats, Canad. J. Biochem. & Physiol. 39:1085-1096 (June) 1961.

Taylor, R. E. Jr., and Fregly, M. J.: Effect of Reserpine on Body Temperature Regulation of the Rat, School of Aerospace Medicine Report. 62-37, Brooks Air Force Base, Texas (Feb.) 1962.

Further studies on the autoregulation of blood flow in peripheral vascular beds were made. In the gastrocnemius muscle of dogs, the level of blood flow autoregulated was relatively proportional to the metabolic rate. An increase in perfusion pressure or flow was followed by an increase in resistance to blood flow and a decrease in perfusion pressure or flow was followed by reduction in resistance.

Stainsby, W. N., and Renkin, E. M.: Autoregulation of Blood Flow in Peripheral Vascular Beds, Am. J. Cardiology 8(8):741-747 (Nov.) 1961.

Stainsby, W. N., and Renkin, E. M.: Autoregulation of Blood Flow in Resting Skeletal Muscle, Am. J. Physiol. 201(8):117-122 (July) 1961.

Studies on the activities of cerebral succinic dehydrogenase and cytochrome oxidase in newborn and adult rabbits agree with the hypothesis that the metabolism of a mammal is transformed from predominantly anaerobic at birth to aerobic with maturation.

Cassin, S., and Herron, C. S. Jr.: Cerebral Enzyme Changes and Tolerance to Anoxia During Maturation in the Rabbit, Am. J. Physiol. 201(8):440-442 (Sept.) 1961.

Studies were made in dogs to determine the pulmonary elimination of physically dissolved

carbon dioxide before and after the administration of a carbonic anhydrase inhibitor, acetazolamide. An increased amount of pulmonary carbon dioxide output came from dissolved gas with a decrease in the amount coming from bicarbonate.

Cain, S. M., and Otis, A. B.: Carbon Dioxide Transport in Anesthetized Dogs During Inhibition of Carbonic Anhydrase, J. Appl. Physiol. 16(8):1023-1028 (Nov.) 1961.

Psychiatry

A study was made of loss of consciousness in 871 college students. Forty-seven per cent had experienced at least one episode of loss of consciousness. In males, trauma to the head, intake of alcohol, pain, and postural change were the most frequent precipitating causes in that order of frequency. In females, pain, trauma to the head, postural change, and infection were the most frequent precipitating factors. Electroencephalographic studies revealed no correlation between the incidence of abnormalities in the EEG and loss of consciousness. The incidence of loss of consciousness in a healthy population is higher than has been previously assumed.

Williams, R. L., and Allen, P. D.: Loss of Consciousness: Incidence, Causes and Electroencephalographic Findings, Aerospace Medicine 33:545-551 (May) 1962.

Radiology

A series of studies has been made on catecholamine metabolism. Gas chromatography has been adapted to the determination of the aromatic acid degradation products in human urine. Reserpine administered to adult human beings resulted in increased excretion of homovanillic acid over a five day period. The effect was interpreted as a result of unbinding of dopamine from body stores in the corpus striatum, lung, intestine and other tissues.

Studies on a patient with metastatic neuroblastoma have shown approximately 1,000 times normal excretion of vanilmandelic acid and 100 times normal excretion of homovanillic acid. The excretion of these aromatic acids decreased during radiation therapy. Homovanillic acid is the major terminal metabolite of dopamine which is the immediate precursor of norepinephrine. No physiologic effect was apparent following the ingestion of reserpine by normal healthy adults which resulted in remarkably elevated homovanillic acid excretion. When patients with Parkinson's disease were given reserpine, the low homovanillic acid excretion was increased and the patients manifested increased tremor, rigidity, and hypokinesia.

Williams, C. M., and Sweeley, C. C.: A New Method for the Determination of Urinary Aromatic Acids by Gas Chromatography, J. Clin. Endocrinol. & Metab. 21:1500-1504 (Nov.) 1961.

Greer, M., and Williams, C. M.: Catecholamine Metabolism in Neuroblastoma, Soc. Ped. Res., Atlantic City, N. J., p. 115 (May) 1962.

Greer, M., and Williams, C. M.: Effect of Reserpine on the Metabolism of Dopamine, Neurology 12:295 (Apr.) 1962. (abst.)

Williams, C. M.: The Effect of Reserpine on Dopamine Metabolism in Humans, J. Neurochem. 9:335-336 (May-June) 1962.

Mice given a single dose of 700 roentgens of x-ray therapy were compared with mice given three intraperitoneal injections of nitrogen mustard. Chromosome aberrations in the regenerating liver were found in a high proportion of cells after a single dose of x-rays. Abnormalities in the nitrogen mustard treated group did not differ from the rate in the controls. Mutations may contribute a real but not decisive part in natural and radiation-induced aging.

Stevenson, K. G., and Curtis, H. J.: Chromosomal Aberrations in Irradiated and Mustard Treated Mice, Radiation Research 15:774-784 (Dec.) 1961.

Twenty patients with hyperglycemia, but without gastrointestinal symptoms, were studied for fat absorption following the ingestion of fat labeled with radioactive iodine. Four patients were considered to have pancreatic insufficiency. Diabetic patients with a known history of chronic alcohol ingestion should be suspected of having pancreatic exocrine insufficiency regardless of the duration of the diabetic state, the presence of a family history of diabetes, or the lack of gastrointestinal symptoms.

Balash, W. R., and Williams, C. M.: Latent Pancreatic Exocrine Insufficiency in Patients with Hyperglycemia, Am. J. Med. Sci. 242:193-200 (Aug.) 1961.

A study has been made by the mathematical technique of factor analysis to determine whether a model for medical diagnosis of suspected thyroid disease could be devised. Eleven laboratory and clinical measurements were analyzed. The method has promise.

Overall, J. E., and Williams, C. M.: Models for Medical Diagnosis: Factor Analysis, Part Two,

Experimental, Medical Documentation 5:57-59 (July) 1961.

Surgery

Long range studies on gastric secretion have been continued. Dogs were prepared with Heidenhain pouches. A linear relationship was found between the blood alcohol level and the gastric secretory response after administration of intravenous alcohol. The response to alcohol is not mediated by the adrenal, pancreas, or hypophysis. Isolation of the cerebral circulation markedly decreases or abolishes the gastric secretory response to parenteral alcohol. This effect may involve the release of a neurohumoral agent.

Dogs were studied after segmental gastric resection and pyloroplasty. Loss of the storage capacity of the stomach exerted a greater effect upon malabsorption than did interference with the pyloroantral pump. Disruption of the pump mechanism significantly increased the excretion of fat, but had little effect upon the excretion of protein. Pyloroplasty, unaccompanied by gastrectomy, had an insignificant effect upon fecal excretion of fat and protein.

Weise, R. E.; Schapiro, H., and Woodward, E. R.: Effect of Parenteral Alcohol on Gastric Secretion, Surgical Forum 12:281-282, 1961.

Jordan, P. H., Jr.: Contribution of Functional Ablation of the Pyloroantral Mechanism to Malabsorption in Gastrectomized Dogs, Surgery 50: 820-823 (Nov.) 1961.

Dragstedt, L. R.: The Pathogenesis of Gastric and Duodenal Ulcers, Annals of N.Y. Acad. Sciences 99:190-197 (Feb.) 1962.

Well established lesions of keratitis in the rabbit cornea produced by herpes simplex virus can be promptly cured by the local instillation of 5-iodo-2'-deoxyuridine (IDU). The importance of this observation is the indication that antimetabolic drugs can be found which selectively inhibit the synthesis of virus with no apparent harm to surrounding tissues. This chemotherapeutic agent appears to be effective in herpes simplex keratitis in man as well as in experimental keratitis in rabbits.

Kaufman, H. E.; Nesburn, A. B., and Maloney, E. D.: IDU Therapy of Herpes Simplex, Arch. Ophthal. 67:583-591 (May) 1962.

Kaufman, H. E.: Clinical Cure of Herpes Simplex Keratitis by 5-Iodo-2-Deoxyuidine, Proc. Soc. Exp. Biol. and Med. 109:251-252 (Feb.) 1962.

Comparison of the dye test and fluorescence inhibition titers on the serum of five patients with proven ocular toxoplasmosis indicates that fluorescence inhibition is not sufficiently sensitive for diagnosis in the study of ocular disease.

Kaufman, H. E.: Toxoplasmosis: Its Diagnosis and Treatment, The Indian Practitioner 15:17-28 (Jan.) 1962.

Twenty-four consecutive patients with recurrent or metastatic cancer of the breast were treated by bilateral oophorectomy and adrenalectomy when they were first seen. Fourteen patients secured marked subjective and objective improvement. The findings to date suggest that this procedure is useful as soon as metastatic lesions from breast carcinoma are found.

Dragstedt, L. R.: Immediate Oophorectomy and Adrenalectomy in Metastatic Breast Cancer, Proc. Nat. Acad. of Sciences 47:1069-1071 (July) 1961.

Rabbits received a transplant of an anaplastic carcinoma. Hypercalcemia, hypophosphatemia and bone resorption, simulating hyperparathyroidism, produced terminal hypercalcemic nephropathy which was a factor in the death of the animals.

Wilson, J. R.; Merrick, H., and Woodward, E. R.: Hypercalcemia Simulating Hyperparathyroidism Induced by XV-2 Carcinoma of Rabbit, Annals of Surgery 154:485-490 (Oct.) 1961.

The oxidation of cholesterol labeled with radioactive carbon in the isolated perfused rat liver was studied. Physiologic solutions of cholesterol were more effective than artificial emulsions in the conversion of liver cholesterol to bile acids. The only labeled product isolated from ethanol extracts of the liver was found to be identical with cholesterol.

Danielsson, H.; Insull, W., Jr.; Jordan, P. H., and Strand, O.: Metabolism of 4-C¹⁴-cholesterol in the Isolated Perfused Rat Liver, Am. J. Physiol. 202:699-703 (Apr.) 1962.

The analgesic effect of heroin was found to be two to four times that of morphine for relief of severe postoperative pain during the first 150 minutes after injection in 522 patients.

The rate of contraction of myocardium from the isolated atria of rats varied according to thyroid activity. Atria from hyperthyroid rats accelerated faster than those from athyroid or euthyroid rats in response to warming and to epinephrine. Reserpine did not affect acceleration during warming; the amount of thyroid hormone appeared to be of greater significance in control of the rate of atrial contraction than the presence or absence of reserpine.

Reichle, C. W.; Smith, G. M.; Gravenstein, J. S.; Macris, S. G., and Beecher, H. K.: Comparative Analgesic Potency of Heroin and Morphine in Postoperative Patients, J. Pharmacol. & Exper. Therap. 136:43-46 (Apr.) 1962.

Thier, M. D.; Gravenstein, J. S., and Hoffman, R. G.: Thyroxin, Reserpine, Epinephrine and Temperature on Atrial Rate, J. Pharmacol. & Exper. Therap. 136:133-141 (May) 1962.

A fully automated shuttle-box which operates on 110 volt. A. C. electric current has been designed for avoidance conditioning of rats subjected to experimentation.

Studies on activation and interference, produced by electrical stimulation of the cortex in conscious man during the course of intracranial operations, have been made. Evidence of effects on the primary motor area, primary sensory area and various other areas indicates a complex system of neuronal circuits exists which unites the two hemispheres within the higher brain stem.

King, F. A.; Achenbach, K. E., and Levine, S.: A Fully Automated Shuttle-Box for Avoidance Conditioning, Psychological Reports 9:377-390 (Sept.) 1961.

Roberts, L.: Activation and Interference of Cortical Functions; in D. E. Sheer, ed., Electrical Stimulation of the Brain, Austin, Univ. Texas Press, p. 534-553, 1961.

Bladder stones were produced in rats following experimental introduction of small metallic foreign bodies. The administration of DL methionine in the diet produced sufficient acidification to prevent growth of magnesium but not of calcium stones. In the presence of infection with proteus organisms no benefit was obtained.

Miller, G. H., Jr.; Moore, J. D.; McClane, T. K., and Sapp, E. W.: Urine Acidification with Methionine and Its Effect on Stone Formation in the Rat, J. Urology 87:988-990 (June) 1962.

Meetings

September

Second Annual Physicians' Respiratory Diseases Seminar, September 14-15, Duval Medical Center, Jacksonville Florida Psychiatric Society, Fall Meeting, September 20-22, Palm Beach Towers, Palm Beach

Postgraduate Seminar of the Duval County Medical Society, September 21-22, Auditorium, Duval Medical Center, Jacksonville

Cardiovascular Seminar, September 27-28, University of Florida College of Medicine, Gainesville

October

Florida Academy of General Practice, Fourteenth Annual Scientific Assembly, October 10-13, Civic Center, Lake-

Symposium on Medical Use of Radioisotopes, October 17, Hotel Americana, Bal Harbour

Postgraduate Symposium in Orthopaedics, Trauma, Minor Surgery and Office Orthopaedics, October 17-19, Auditorium, Mound Park Hospital, and Clinic, American Legion Hospital for Crippled Children, St. Petersburg

Florida Society of Anesthesiologists, October 19-20, Sheraton-Tampa Motor Inn, Tampa

Florida Orthopedic Society, Fall Meeting, October 25-27, Port Paradise Hotel, Crystal River

November

Seminar in Diagnosis of Cardiac Arrhythmias, November 1-4, Tampa General Hospital, Tampa

Fourth Annual Medical Seminar Cruise, November 23-30, M/S Riviera from Fort Lauderdale, University of Florida College of Medicine, Gainesville

Florida State Surgical Division, International College of Surgeons, Fourth Annual Fall Meeting, November 29-30, University of Florida College of Medicine, Gainesville

Dermatology

Fungus Infections of the Skin

Too glibly diagnosed Ubiquitous but not exclusive

WHAT OTHER DISEASES MUST BE CONSIDERED?



"Athlete's foot," dermatophytosis of the toes and feet (fig. 1), is widespread among the population, but other inflammatory diseases of the feet are also frequent and hence should not be overlooked. Contact dermatitis from shoes is often mistaken for ringworm. Involvement of the dorsa of the toes and feet and the sharp delineation of the dermatitis mark the imprint of the offending footwear. Bacterial infection, psoriasis, lichen planus, secondary syphilis and other dermatoses may also elect to localize on the feet. Nor is the "therapeutic test" foolproof, for griseofulvin is far from a panacea for fungus infections of the



Deformed, opaque, discolored, crumbling nails do not necessarily indicate fungus infection (fig. 2). Psoriasis may produce almost indistinguishable changes. Microscopic study of scrapings from the diseased nails will often resolve the dilemma. Moniliasis (candidiasis) of the nails is usually associated with paronychia, whereas ringworm infection is not. Remember, too, that griseofulvin is ineffectual for monilial infections.





Then there is ringworm of the scalp (fig. 3). Almost always it is a disease of childhood, for postpubertal adolescents and adults are immune. Affected hairs are broken off and lusterless and the scalp is scaling or inflamed. Two fundamental procedures for diagnosis of the infection are (1) direct microscopic examination of hairs in 10 per cent potassium hydroxide (KOH) for spores and (2) inspection under Wood's lamp ("black light") for fluorescence. Rule out patchy diseases of the scalp such as psoriasis, seborrheic dermatitis, alopecia areata, discoid lupus erythematosus and syphilis.

Infection of the ear canals, external otitis (fig. 4), is caused by bacteria (Pseudomonas aeruginosa, staphylococci, streptococci), and not by fungi. Psoriasis, seborrheic dermatitis, contact dermatitis, and atopic dermatitis may appear in the ear canals; so search beyond the ears for

diagnostic clues.



Tinea versicolor (fig. 5) is often confused with vitiligo. Its pale spots result from failure of pigmentation due to exclusion of sunlight by the waxy-scaled lesions. In scrapings, organisms are readily identified under the microscope. Accurate diagnosis is essential, for with vitiligo the prognosis for recovery is poor; with tinea versicolor, just the opposite.

PREPARED BY THE COMMITTEE ON SCIENTIFIC PROJECTS
FLORIDA SOCIETY OF DERMATOLOGY

President's Page

"The Winter of Our Discontent"

(With Apologies to John Steinbeck)*

In this novel, Ethan Allan Hawley, the principal character, exemplifies the constant contest, within ourselves, of good and evil. A young man of high character, bearing an old and respected name, he fights the formidable forces with which the modern world attacks personal integrity. He is a good, proud man, with educational attainments, but is not very successful in his pursuit of material gain. The story is quite entertaining and discusses in detail the general question of whether one man should stand apart in his decisions, or conform to the general trend.

But what does this have to do with medicine? Let us discuss for a few minutes the relationship of this theme to the problems confronted by the dedicated physician in Florida.

Coincident with the times, there is a changing character to American medicine. Equipped as we are to combat severe illness and disease with modern techniques and wonder drugs of various sorts, it is a strong temptation to use these methods for minor or trivial conditions for which they were not intended. Sometimes the physician is pushed into this procedure by the demands of patients, feeling that if he does not prescribe an antibiotic for an ordinary self-limited disease, somebody else will do so. Or, if he does not run the whole gamut of diagnostic tests, somebody else may find an abnormal condition which he failed to mention. Lay magazines constantly publish the details of illnesses and of drugs concerning which the public is not familiar. This situation creates overanxiety from the patient, and unnecessary demands upon the physician. So-called health columns in the newspapers, television programs, and books on medicine designed for laymen's reading have caused much undue concern, and considerable conversation, about health problems. The patient becomes too restless to give nature a chance, and there is undue pressure upon the doctor to "do something." Very often, as we all know, it is the part of wisdom to do nothing. The phrase "masterful inactivity" does not imply neglect. But the public, except under unusual circumstances, does not feel that a fee has been earned unless there is something more tangible than advice given.

The physician in the community has long been a highly respected, beloved citizen. Much has been written and said recently about the impairment of this public image. Unless the mirror is distorted, one sees in it the true reflection of the individual. So what can we do, as individuals, to reflect an accurate image of the doctor as we know him to be? Basically, we can accomplish a great deal by rendering good medical care, by charging fair fees for this service, and by showing an active interest in civic and public responsibilities. Every doctor owes a debt to the community where he lives and practices medicine. He may be very busy with his professonal obligations, but this does not excuse him from giving something of himself to some civic project. He must be interested in politics as a good citizen. His training and experience should endow him for leadership in community effort. And even his professional existence may depend upon this interest. Each year more bills of medical significance are introduced in the legislature. The lobbyists are constantly at work in this field. So, the citizen doctor has a responsibility for support of organized medicine. The county and state medical societies and the A.M.A. are fighting the battle for him and for the ultimate medical welfare of the public. As an outstanding member of the community, the physician must be alert to these responsibilities which he bears. By virtue of training and experience, he is well equipped. As stated by St. Paul in his Epistle to the Galatians, (Chapter 6, Verse 9): "And let us not be weary in well doing; for in due season we shall reap, if we faint not." *Steinbeck, John: "The Winter of Our Discontent," Viking Press, 1961.

Women wopinerian



The Third Party in Medicine

Patients and doctors are getting farther and farther apart in their mutual respect. One of the causes of this loss of respect is the third party, either a lawyer or an insurance company. We doctors in our eagerness to collect for all of our services have lost a part of our patients' respect. We have been brought into arguments which should have been between the patient and his insurance company, with the lawyers calling the shots. At all times we have had the interest of the patient at heart and so we have assumed the responsibility of collecting the patient's bill from an insurance company. This responsibility is not ours. The contract is between the patient and the insurance company, and even though the contract is between Blue Shield and the patient, we are in no way connected with this contract. Our course should be clear: respond to our patient's demands and in a like manner demand from him the payment of the bills for which he has contracted. His financial responsibility of course has to be considered. The patient can make such demands on his insurer as his policy covers under that particular liability. Once responsibility is established between the doctor and the patient, understanding between them will also be established.

Security will be one of the minor losses with this newer concept, but our Republic was established on freedom, not security. So we will gain freedom of decisions which will give the patient better care and bring to us freedom from criticism which now comes from the various agencies which have to do with the financial health of our patients. Our responsibility is only to give the patient the best medical care that we can provide. His responsibility is to pay his bills.

ROBERT B. SMALLWOOD, M.D. St. Petersburg

Bacterial Sensitivity

After extensive examination of the bumblebee relative to weight, length, wingspan, contour and other details, aeronautic engineers declared it impossible for this insect to fly, but the bumblebee didn't know.

Scientific studies concerning bacterial infection and drug sensitivity lead one to wonder how his ancestors reached adulthood without benefit of antibiotics. After reading reports of culture and sensitivity, one may also wonder why his patient became symptom-free and his urine returned to normal while he was taking an antibacterial drug or antibiotic which on the culture showed the drug used to be of no value.

Many patients have been "clinically cured" on taking sulfonamides only to be told that the offending organism is sulfonamide-resistant.

This contradiction has been explained on laboratory factors which inhibit, and host factors which enhance, antibacterial action of sulfonamides. Ability to inhibit the action of sulfonamides has been recognized as a characteristic of certain natural extracts, some of which are used in the preparation of culture mediums. Strong circumstantial evidence has been offered to show that para-aminobenzoic acid is the substance responsible for the inhibition.

Clinicians are inclined to forget that the blood and lymph contain certain chemical substances of a complex nature, antitoxins, lysins and other antibodies which are the basis of the body's defense against injurious agents of various kinds. Elevated temperature is a host factor that is sometimes induced or encouraged to a degree to combat infection.

Perhaps no explanation can be made at present to account for the in vivo and in vitro responses to antibiotics, but every day clinicians encounter this discrepancy.

Without doubt, advantage should be taken of the assistance obtained from the bacterial laboratory. To quote Cocco and Smith, "A degree of fortitude, of folly, or of both is required of the Clinicians who prescribe a drug that has been reported by the laboratory to be ineffective." But, how can one be criticized for using a medication that brings about a clinical cure? Nothing succeeds like success.

Many medical students of the past 15 years have been taught to treat the laboratory instead of the patients. In my opinion, one cannot be dogmatic and must keep an open mind in preserving the health of individuals. Patients are people, not Petri dishes.

Frank M. Woods, M.D. Miami



Association News

1963 Legislative Activities Highly Successful

The legislative program of the Florida Medical Association met with notable success during the 1963 session of the Florida Legislature, which adjourned on June 19. Of the 2,546 House bills and 1,413 Senate bills introduced during the 60 days of regular session and 19 days of extended session, approximately 75 bills, both of general and local application, were of interest to the medical profession because they affected public health.

Of major importance was the Medical Assistance for the Aged measure as sponsored by the Association, which was signed into law by Governor Bryant on May 22. This new law further implementing the Kerr-Mills Law in Florida became effective on July 1. Some 40 states have now implemented or authorized the Kerr-Mills medical care program for the aged needy sick, and all 50 states have Old Age Assistance programs in effect utilizing increased federal matching funds available through the Kerr-Mills program.

Under Florida's Medical Assistance for the Aged program, services now authorized for eligible applicants are limited to hospital care and visiting nurse services on the basis of need. To be eligible for the program benefits a person and/or spouse may have income sufficient for basic and special needs but not enough to cover the cost of medical care. Annual income may not exceed \$1,200 for a single person and \$2,400 for a man and wife. Resources may consist of a homestead irrespective of the value, and the cash value of all resources, excluding \$750 cash value of life insurance, may not be in excess of \$1,000 for a single person and \$2,000 for a man and wife. Payment may be made for not more than 30 days of hospitalization in any 12 months' period for an acute illness or injury. It will be computed on the average cost per diem of the hospital, or \$15 per day when an average cost per diem has not been established. Payment for home nursing care may be made for the number of visits needed and prescribed by a physician for the first 30 days immediately following the date of discharge from a hos-

pital. A flat rate of \$4 will be paid for each nurse's visit. For the 1963-64 and 1964-65 biennium state funds appropriated were \$3,250,000 (39.31 per cent) and federal funds \$4,881,646 (60.69 per cent). The total of \$8,131,646 includes the cost of administration. Counties will receive financial assistance in that the program will now pay for care rendered needy persons aged 65 and over. Financing and administration will be through state-federal funds in lieu of county-state.

Only citizens of the United States and residents of Florida are eligible. Migrant workers, transients, and exiles of foreign countries are not included.

The program will be administered jointly by the State Board of Health and the State Department of Public Welfare with the advisory assistance of a Medical Advisory Committee which includes two members of the legislature as recommended by the President of the Senate and Speaker of the House.

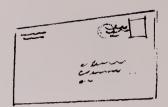
Other legislation of interest was the creation of a State Commission on Aging, composed of 19 members, to deal with the needs of the aging people of the state and to make legislative recommendations; it was designated the agency to handle federal programs not assigned another agency. A Legislative Council was also authorized to investigate and study the feasibility of establishing nursing home facilities for the indigent aged, with instructions to report its recommendations to the 1965 legislature. In addition, a bill was passed relating to the practice of medicine in counties with a population of 100,000 or less. It provides that any noncitizen who holds a valid license to practice medicine in the country of which he is a citizen is authorized to be employed as a house physician, resident physician, assistant resident physician or intern in a hospital for a period of five years. This bill was passed as a local bill intended for Key West-Monroe County. The Medical Practice Act permits

only a two year period of employment.

The "Good Samaritan Bill," providing immunity for physicians from civil libel for rendering emergency care, and the "Privileged Communications Bill," prohibiting any doctor of medicine or psychiatrist giving or being required to give testimony as a witness, to disclose any information communicated to him in a confidential manner in connection with his professional capacity, both failed to pass. Other proposed legislation not enacted into law included bills granting osteopaths rights by law to use the facilities of tax-supported hospitals; exempting private proprietary hospitals from minimum requirements of hospital licensure law; and placing a sales tax on certain professional and business services.

An expression of appreciation is extended to the County Medical Societies and individual physicians for their assistance and untiring efforts in making the Association's 1963 legislative program successful.

SAMUEL M. DAY, M.D., PRESIDENT-ELECT FLORIDA MEDICAL ASSOCIATION
JACKSONVILLE



Letters

Dear Sir:

The House of Delegates of the Florida Medical Association in May 1963 adopted the following:

"It is recommended that advertising by lay clinical laboratories in official medical journals and in technical exhibits should be discontinued."

The proposal for this recommendation did not appear in the original resolutions published prior to the meeting. If it had been, several of us would have appeared before the Reference Committee to participate in the discussion. It was announced for the first time as an addition at the final meeting of the House of Delegates, much too late in the day to delay several hundred busy doctors by raising an issue at the last minute.

As Editor of our County Medical Bulletin, I have been "pressured" by pathologists to automatically exclude advertising by lay clinical laboratories. The only reason ever given is that the American Society of Clinical Pathologists believes it to be improper.

Our attitude has been up to the present time the ASCP does *not* have control of all clinical laboratories. This may be good or bad, but there is good reason to think that laboratories controlled by pathologists should be good enough to be able to stand competition by other clinical laboratories.

It seems perfectly permissible for the pathologists to agree to anything they wish, but it does not therefore follow that no *other* laboratories can be permitted to advertise.

A large number of convalescent centers and psychiatric facilities controlled by doctors now advertise in our medical publications. So, as well, do a number which are not operated by physicians. If the physicians involved decide to advertise none of their facilities, should they accordingly be permitted to insist that nobody else's convalescent center may advertise?

If the physicians who own optical laboratories agree not to advertise their facilities, should we exclude advertising from all ethical optical laboratories?

All of this has to do with advertising only in strictly professional publications and technical exhibits.

We must leave no room for doubt about motivation. We are involved in a nationwide fight for our freedom. We believe that our effectiveness as physicians depends on maintaining the free enterprise system. If this recommendation will help to progressively eliminate all honest competition by laboratories not run by pathologists we are guilty of conspiring against freedom ourselves.

This is not a suitable method of discipline. If there are laboratories performing in any improper fashion, action should be taken specifically against those laboratories. No professional publication would undertake knowingly to accept advertising from any type of facility which behaves improperly.

The pathologists, with good grounds, are trying to raise clinical laboratory standards all over the country. This is a very commendable effort, and I am all in favor. But they are going to bring down storms of criticism and abuse upon themselves and upon the medical profession if they appear to use unfair means to shut out fair competition.

I hope the Council on Specialty Medicine will reconsider this recommendation.

W. E. Manry Jr., M.D., Editor Imperial Medical Bulletin Polk County Medical Association Lake Wales

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA

LOMOTIL CASE REPORT
Patient: S. Z. Age: 58 Sex: F Wt.: 130
Diagnosis: Functional diarrhea Number stools per day: 6-8
marine: 4 days
Prior Treatment: Paregorio Dosage: 5 mg. q.i.d. Dosage: 5 mg. q.i.d.
LOMOTIL Results: Excellence Side Effects: None Comments and Clinical Appraisal: Complete, prompt relief

To control diarrhea...promptly prescribe LOMOTIL promptly

Each tablet and each 5 cc. of liquid contains: 2.5 mg. of diphenoxylate hydrochloride (Warning: may be habit forming) and 0.025 mg. of atropine sulfate



The direct, well-localized activity of Lomotil relieves spasm and cramping and provides prompt symptomatic control of virtually all diarrheas.

Numerous investigators have remarked on the effectiveness of Lomotil in patients with diarrhea uncontrolled by other agents.

Weingarten and his associates¹ found it "an excellent drug . . . efficacious where other drugs have failed. . . ."

Hock² obtained "results superior to prior medications in 68.3 per cent of 41 patients."

Since Lomotil controls diarrhea so consistently, it is only rational to prescribe Lomotil *before* other agents have a chance to prove inadequate. To control diarrhea promptly, prescribe Lomotil promptly.

Lomotil is an exempt narcotic, its abuse

liability being comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of the latter is added to discourage deliberate overdosage.

1. Weingorten, B.; Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiorrheol Agent, Amer. J. Gostroent. 35.628-633 (June) 1961. 2. Hock, C. W.: Relief of Diarrheo with Diphenoxylote Hydrochloride (Lomotil), J. Med. Ass. Georgio 50:485-488 (Oct.) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine

Announcing

THE TWENTY-FOURTH ANNUAL MEETING OF

THE AMERICAN FRACTURE ASSOCIATION

November 10-15, 1963 — Americana Hotel

Miami Beach, Florida

A highlight of the meeting will be a symposium on Fracture Fundamentals to be presented by Wallace E. Miller, M.D., Chairman, Department of Orthopaedics, University of Miami School of Medicine and his staff.

OTHER GUEST SPEAKERS

Hugh Burke, D.D.S., Dixon, Ill.
Alexander Kushner, M.D., Miami, Fla.
Joseph C. Flynn, M.D., Orlando, Fla.
Joseph G. Matthews, M.D., Orlando, Fla.
Herbert W. Virgin Jr., M.D., Miami, Fla.
A. H. Diehr, M.D., St. Louis, Mo.
Philip T. Holland, M.D., Bloomington, Ind.
John E. Burch, M.D., Miami, Fla.
J. Gordon McAllister, M.D., Fort Lauderdale, Fla.
George Garceau, M.D., Indianapolis, Ind.
Robert W. Bailey, M.D., Ann Arbor, Mich.
William Price, M.D., Houtson, Texas
George R. Ruiz, M.D., Martinsburg, W. Va.
Harold O. Hallstrand, M.D., S. Miami, Fla.
Nathan E. Baer, M.D., Monroe, Wisc.
William Johnson, M.D., Galesburg, Ill.
George F. Pennal, M.D., Toronto, Canada
Donald Y. Stewart, M.D., Riverhead, N.Y.
Benjamin I. Golden, M.D., Elkins, W. Va.

Martin Dobelle, M.D., Washington, D. C.
Robert Elliott, M.D., Houston, Texas
Leo Cooper, M.D., Gary, Ind.
Joel E. Adams, M.D., San Bernardino, Calif.
C. Philip Fox, M.D., Washington, Ind.
Irvin H. Scott, M.D., Sullivan, Ind.
Augusto Sarmiento, M.D., Miami, Fla.
Joseph Kalbac, M.D., Miami, Fla.
Harvey E. Billig Jr., M.D., Los Angeles, Calif.
Charles F. Woodhouse, M.D., Chicago, Ill.
Arthur A. Michele, M.D., New York, N. Y.
Roger Anderson, M.D., Seattle, Wash.
Capt. Thomas J. Canty, Camp Pendleton, Calif.
R. Fernandez Torres, M.D., Caracas, Venezuela
Earl McBride, M.D., Oklahoma City, Okla.
Jorge B. Colon, M.D., Ponce, Puerto Rico
Michael P. Mandarino, M.D., Philadelphia, Pa.
Harold A. Fenner, M.D., Hobbs, New Mex.
L. Irigoyen Dotti, M.D., Barquisimeto, Venezuela

Lectures, round-table luncheon discussions, Medical motion pictures, technical exhibits, scientific exhibits, and entertainment for visiting wives.

For further information concerning the meeting write Joseph J. Ruskin, M.D., Program Chairman 204 Palm Avenue, Tampa, Florida

WILLIAM B. TERHUNE, M.D.

THE SILVER HILL FOUNDATION

New Canaan

Connecticut

Announces:

Appointment available for Senior Associate. Board Certified in Psychiatry to join our Group in the active practice of pyschiatry. The Silver Hill Foundation is a psychotherapeutic unit for the treatment of the functional nervous disorders. The setting is that of a comfortable country home where a limited number of patients are under intensive, re-educational treatment for a period of several weeks.

Ideal work conditions, scientific freedom and guaranteed income. Only well qualified physician, capable of advancement should APPLY TO: Dr. William B. Terhune, Medical Director, New Canaan, Connecticut.

Associates: Dr. Marvin G. Pearce

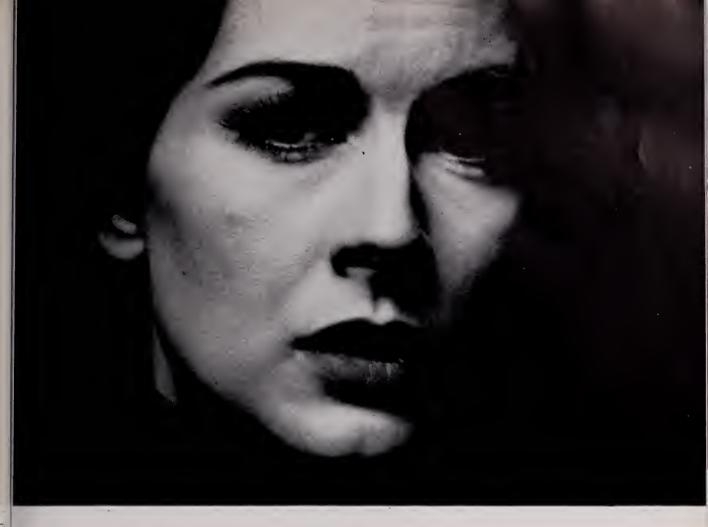
Dr. Robert B. Hiden

Dr. William M. White

Dr. William D. Wheat

Dr. Warren A. Mann

Dr. Morgan F. Moore



lelieves Anxiety and Anxious Depression

le outstanding effectiveness and record of ety with which 'Miltown' (meprobamate) ieves anxiety and anxious depression has en clinically authenticated time and again ring the past eight years. This, undoubtedly, one reason why physicians still prescribe eprobamate more than any other tranquilizer the world.

ght drowsiness may occur with meprobaite and, rarely, allergic reactions. Mepromate may increase effects of excessive cohol. Use with care in patients with suicidal idencies. Massive overdosage may produce ma, shock, vasomotor and respiratory colose. Consider possibility of dependence, parularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d. **Supplied**: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

the original meprobamate Miltown

WALLACE LABORATORIES / Cranbury, N.J.

News

The 57th annual meeting of the Southern Medical Association will be held November 18-21 at New Orleans. The EENT Section will initiate the closed television sessions with the first attempted color production of microscopic ear surgery the morning of the meeting's first day in the Municipal Auditorium.

Dr. Lester R. Dragstedt of Gainesville, Research Professor of Surgery at the University of Florida College of Medicine, has been presented the Distinguished Service Award for 1963 by the American Medical Association.

An unrestricted eye research grant of \$5,000 from Research to Prevent Blindness, Inc., has been announced by the University of Miami School of Medicine. Dr. Edward W. D. Norton is Chairman of the Department of Ophthalmology.

Dr. Walter W. Sackett Jr. of Miami has been elected vice president of the American Academy of General Practice.

Dr. Richard T. Smith of Gainesville, Professor of Pediatrics at the University of Florida College of Medicine, has been chosen by the American Academy of Pediatrics to receive the 1963 E. Mead Johnson Research Award. It will be presented to Dr. Smith at the annual meeting of the Academy October 5-10 in Chicago.

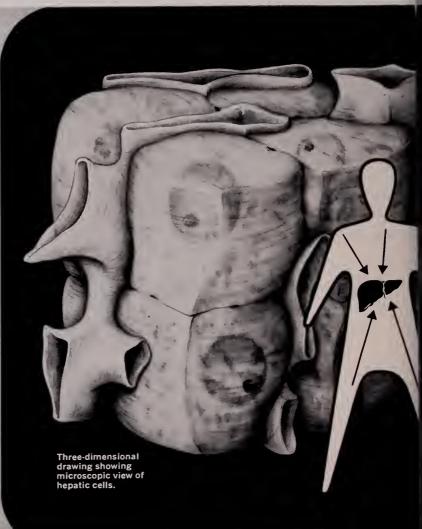
An advanced seminar in the diagnosis of cardiac arrhythmias with emphasis on both clinical and electrocardiographic features has been scheduled for November 1-4 at Tampa General Hospital in Tampa. Members of the faculty include Drs. Harold H. Bix of Baltimore; James L. Gouaux of St. Petersburg; Ralph Miller of Newark; and Albert Kistin of Beckley. It is being directed by Dr. Henry J. L. Marriott, Director of the Cardiology Center at the Hospital.

A regional institute for operating room nurses co-sponsored by the Central Florida Association of Operating Room Nurses is being held November 22-23 at the Langford Hotel in Winter Park.

The Fifth National Cancer Conference sponsored by the American Cancer Society and the

when the liver
is threatened or
damaged by fat
in
cirrhosis
alcoholism
hepatitis
obesity
diabetes





National Cancer Institute will be held September 17-19 in the Bellevue-Stratford Hotel at Philadelphia.

An annual award honoring Dr. William C. Thomas Sr. of Gainesville will be presented, beginning next year, to an outstanding student in obstetrics and gynecology at the University of Florida College of Medicine. It will be known as the Florida Obstetric and Gynecologic Society William C. Thomas Award, according to announcement by Dr. Sam W. Denham of Jacksonville, president of the Society, and Dr. Harry Prystowsky, Chairman of the Department of Obstetrics and Gynecology at the College of Medicine.

Dr. Simon D. Doff of Jacksonville has been elected vice chairman of the Florida Joint Council on Health of the Aging.

The Sixth Annual Medical Progress Assembly of the Birmingham Academy of Medicine has been scheduled for October 6-8 at Birmingham, Ala., in the Tutwiler Hotel.

The Fourth Annual Medical Seminar Cruise sponsored by the University of Florida College of Medicine at Gainesville will be held aboard the M/S Riviera sailing November 23 from Fort Lauderdale to Port Antonio, Montego Bay, Kingston and Nassau returning to Fort Lauderdale November 30. Details may be obtained from the Division of Postgraduate Education of the College of Medicine.

A postgraduate seminar in gynecology and obstetrics is being presented by the Department of Gynecology and Obstetrics of the Emory University School of Medicine in Atlanta October 17-19. Dr. Denis Cavanagh of Coral Gables is a member of the faculty.

Dr. William L. Nylan, Associate Professor of Pediatrics at Johns Hopkins University School of Medicine, has joined the University of Miami School of Medicine as Professor and Chairman of the Department of Pediatrics. His appointment was effective June 1, according to announcement by Dr. Hayden C. Nicholson, Dean.

NETHISCHOL... the original, complete lipotropic formula together with a low fat, moderate protein diet, helps to prevent and treat fatty infiltration and fatty degeneration of the liver, and consequent cirrhosis by helping to...

remove infiltrated fat and thus reduce liver size and tendency to fibrosis contribute to increased phospholipid turnover and regeneration of new liver cells

The suggested daily therapeutic dose of 9 Methischol capsules or 3 tablespoonfuls of Methischol syrup provides:

CHOLINE D	HY	DR	OGE	N.	CIT	RA ⁻	TE*							2.5 Gm.
di, METHIOI	NIN	E												1.0 Gm.
INOSITOL								*					٠	0.75 Gm.
VITAMIN B1	2													18 mcg.
LIVER CONC	FN	TR	ATF	AI	ND	DF	SIC	CA.	TED	1	VF	R**		0.78 Gm.

*Present in syrup as 1.14 Gm. Choline Chloride **Present in syrup as 1.2 Gm. Liver Concentrate

capsules: 100, 250, 500, 1000; syrup: 16 oz. and 1 gallon

Samples of METHISCHOL and literature available from

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Laboratories, division—800 Second Ave., New York 17, N.Y.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

- 1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.
- 2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.
- 3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness ("numbs the pain...not the patient").

- 4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.
- 5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning — may be habit forming.)

W@WALLACE LABORATORIES / Cranbury, N. J.

CLASSIFIED

FOR RENT: Complete office. Ready to move into in the Doctors Building. \$110. per month including air-conditioning, heat, hot water and janitor service. Downtown location, abundance of free parking for patients. Contact S. J. Wilson, M.D., 309 N. E. River Drive, Fort Lauderdale. Fla.

WANTED: General Practitioner, Internist, Pediatrician, to join surgeon in new clinic. Exciting growth enterprise in finest Cape Canaveral location. Arrangements open. Write 69-484, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Excellent general practice and equipment, Miami Beach area, established 30 years same location. Contact: Medical Business Consultants, 1101 N.E. 79th Street, Miami, PL 9-0230.

PEDIATRICIAN WANTED: For association in Hollywood, Fla. Must be Board qualified or certified. For information contact Medical Business Consultants, 1101 N.E. 79th St., Suite 205, Miami, Fla. Telephone PL 9-0230.

WANTED: Pediatrician, ENT, Internist and Dermatologist for new medical building ready Feb. 15. Adjacent to hospital in beautiful location on Gulf of Mexico. Fine practice opportunity. Write 69-510, P.O. Box 2411, Jacksonville, Fla.

MEDICAL OFFICE AVAILABLE: Unusual opportunity for GP or specialist in Miami Beach. Call Jefferson 1-1246 or contact: Dr. Leonard Sakrais, 1500 Bay Rd., Miami Beach, Florida.

FOR SALE: Solidly established Miami Beach general medical practice and equipment. Will introduce and cooperate fully. Leaving practice for psychiatry residency in this area. Write or phone Dr. Greenberg, 350 Washington Ave., Miami Beach. JE 1-7057.

OFFICE SPACE FOR RENT: Medical suite, approximately 600 sq. ft. in separate consultation, two treatment and laboratory rooms. Share secretary and reception room. New professional building, excellent furnishings. Suitable for specialty or general practice. Clarence H. Schilt, M.D., 2161 McGregor Bldg., Ft. Myers, Fla.

WANTED: General Practitioner for Clinic-Hospital. Salary open—plus bonus. Write 69-535, P.O. Box 2411, Jacksonville, Fla.

AVAILABLE: For \$90 enjoy professional suite of 4 rooms air-conditioned in Medical Arts Building, 503 W. Platt, Tampa. Phone 251-1600.

PRACTICE FOR SALE: Ideal for two well suited E.E.N.T. specialists in thriving community where you are needed. Congenial colleagues will support you. 2,600 sq. ft. of air-conditioned space. Off street parking. Modern equipment and complete instruments for examinations of Ophthalmology and Otolaryngology. Deceased was diplomate of O.L.A.R. and member F.A.C.S. Office established over 30 years. For details write Mrs. J. N. McLane, 1212 N. Palafox St., Pensacola, Fla.

FOR SALE OR LEASE: Physician in Highlands section retiring from active practice. Will sell or lease. Write 69-546, P.O. Box 2411, Jacksonville, Fla.

PARTNER WANTED: Pediatrician. Florida license. Generous terms from beginning. Quick advance to equal division of income. Write 69-547, P.O. Box 2411, Jacksonville, Fla.

MODERN MEDICAL SPACE for rent-lease to two doctors. Space available for dentist also, ready for installing equipment. Doctors and dentist to share in utilities, cleaning service and up-keep of interior of building. Also, large modern one room office space, separate with private entrance, for rent to business. The up-keep and utilities may also be shared with doctors and dentist. Rates: \$250 per month each doctor; \$150 per month, dentist; \$75 per month, office business space. All on rent-lease basis. R. E. Pervis, P.O. Box 3147, Forest City, Fla.

LAKEFRONT HOME FOR QUICK SALE: (By owner) 4 bedroom, 3 bath, CBS reinforced concrete steel bungalow and garage on Lake McCoy-Lake Placid. Completely furnished, air-conditioned and heat. Beautifully landscaped, fruit trees, double sprinkler system. Terms if desired. Contact John Francis, 1040 S. Federal Highway, Hollywood, Fla. Phone WA 2-0865.

PROFESSIONAL SUITE: Reception room with nurse's station. Five consulting and examining rooms. Built to a doctor's specifications. Ample space to serve two doctors. Street level. Centrally heated and air-conditioned. Five minutes from Bethesda Memorial Hospital. Ample parking. Immediate occupancy. VERY reasonable rent—last 6 months rent free on 5 year lease. Call Owners or your broker, CR 6-7092 or CR 6-7634, Booth Westerman, Inc., P.O. Box 2013, Delray Beach, Fla.

INTERNIST WANTED: Large multi-specialty group in Florida desires to add a sixth internist to its Department of Internal Medicine. Applicant should be 35 years of age or under and board eligible. Write 69-544, P.O. Box 2411, Jacksonville, Fla.

INTERNIST WANTED: For association in group practice. No investment necessary. Gastroenterology training desirable. Academic, financial, personal satisfaction. Beautiful area. Fine hospitals. Modern, completely equipped medical building. Write 69-542, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: \$3,000 will buy a well established, fully-equipped office for general practice in West Palm Beach. Air-conditioning, basal meter, ultrasonic, diathermy, etc. Excellent location. Terms can be arranged. Write 69-541, P.O. Box 2411, Jacksonville, Fla.

POSITION WANTED: INTERNIST-CARDIOL-OGIST, Board certified, age 38. Protestant, Florida license, interested in group, association or industrial. Available immediately. Please reply to P.O. Box 1670, Wilmington 99, Delaware.

SURGEON: Age 40, Board certified in general surgery and two and one-half years' training in vascular surgery, wants to relocate. Has Florida license. Available immediately. For review of his record please contact Medical Placement, 15 Peachtree Place, N.W., Atlanta, Ga.

GENERAL PRACTITIONER wanted for full time group practice in Central Florida in Fall of 1963. This is a large established practice in pleasant community. Please send resume to 69-543, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER looking for location in a growing area. Will consider loose association with established man. Write full particulars first letter. Write 69-545, P.O. Box 2411, Jacksonville, Fla.

SURGEON: Desires relocation in solo or group in Florida. Have Florida license, ACS and Board qualified. Will do some general practice. Write full details first letter. Write 69-534, P.O. Box 2411, Jacksonville, Fla.

ANESTHESIOLOGIST WANTED: Immediate opening for well qualified young Anesthesiologist on percentage basis. Working with established group. Phone FR 1-2601, Miami, Fla.

FOR SALE: Belltone Audiometer, slightly used, excellent condition. Contact ACL Railroad Co., Medical Dept., 500 Water St., Jacksonville, Fla. Phone EL 3-2011, Ext. 697—Price \$150.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 3. This service is for the use of physicians seeking locations, as well as physicians seeking associates.



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.

Supplied: Bottles of 50 tablets.

CML-9646

Miltrate

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / Cranbury, N. J.

Emory Postgraduate Seminar !N

Gynecology and Obstetrics

offered by

The Department of Gynecology

and

Obstetrics
Emory University School of
Medicine

OCTOBER 17, 18, 19, 1963

Faculty:

Denis Cavanagh, M.D. University of Miami School of Medicine

Robert Noyes, M.D. Vanderbilt University School of Medicine

and

Members of the Faculty of Emory University School of Medicine 69 Butler Street, S.E. Atlanta 3, Georgia

RADIOLOGICAL HEALTH

AND SAFETY SERVICES

- SURVEY AND CALIBRATION OF X-RAY MACHINE AND TELETHERAPY UNITS.
- LEAK TEST SEALED RADIOISOTOPIC SOURCES.
- PROCUREMENT AND COMPLIANCE AIDS FOR FEDERAL AND STATE LICENSING.
- RADIATION THERAPY, PROTECTION AND SAFETY CONSULTATION.
- DECONTAMINATION OF RADIOACTIVITY FROM BOTH AREAS AND EQUIPMENT.
- CALIBRATION AND MAINTENANCE OF RA-DIATION DETECTION INSTRUMENTS.
- FACILITY DESIGN.
- RADIOISOTOPIC BIOASSAY AND ANALYT-ICAL RADIOCHEMISTRY.

Dynatomic's staff includes Certified health physicists and experts in nuclear medicine.

Complete laboratory facilities.

RADIOLOGICAL SCIENCES AND SERVICES

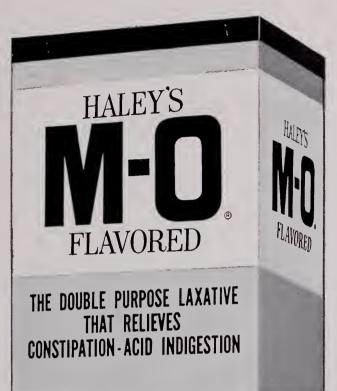
For Information

Write or Call

DYNATOMICS, Inc.

180 MILLS STREET, N. W. ATLANTA, GEORGIA 30313 TELEPHONE 525-4973 AREA CODE 404

NOW ALSO IN FLAVORED FORM!



BOTTLES OF 4 OZ., 8 OZ., 1 PT., 1 QT.

Antacid-Laxative-Lubricant to help correct constipation

Magnesium Hydroxide plus pure mineral oil make *Haley's M-O* a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and attendant gastric hyperacidity.

The oil globules in *Haley's M-O* are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is thus avoided and a comfortable evacuation is effected through the stimulation of normal intestinal rhythm and blunted defectaion reflex.

May we send samples for your evaluation? Just write:

THE CHAS. H. PHILLIPS CO.

Division of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.

Specialized Service

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

MEDICAL PROPERTY COMPANY

FORTWAYNE INDUNYA

Professional Protection Exclusively since 1899

MIAMI OFFICE: H. Maurice McHenry, Rep. 149 Northwest 106th Street, Miami Shares Tel. Plaza 4-2703



... to Clarity and Interest

Cerebro-

A safe effective cerebral stimulant and vasodilator for your forgetful aging patient. On Cerebro-Nicin therapy, your patient shows improvement in social activity and relationships, and greater concern with personal appearance.

FORMULA:

Tetrazole)	100 mg
Nicotinic Acid	100 mg
Niacinamide	5 mg
Vitamin C	100 mg
Thiamine HCI	25 mg
Riboflavin	
Pyridoxine	3 mg
1-Glutamic Acid	50 mg

INDICATIONS: Apathy, dizzy spells, mild behavior disorders, mental confusion, functional memory defects. AVERAGE DOSE: One capsule three

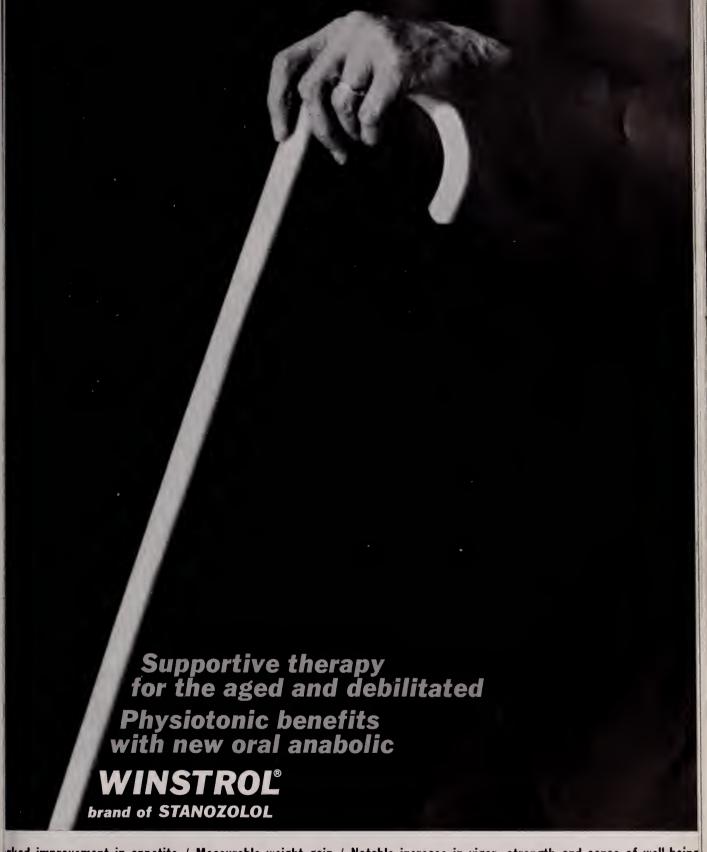
times daily. AVAILABLE: Bottles of 100 and 500

CAUTION: Most persons experience a flushing and tingling sensation after taking a higher potency niacincontaining compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause for discontinuance of the drug if the patient is forewarned to expect the reaction.

WARNING: Contraindicated in the presence of epilepsy.



Write for samples and literature... THE BROWN PHARMACEUTICAL COMPANY 2500 West Sixth Street, Los Angeles 57, California



rked improvement in appetite / Measurable weight gain / Notable increase in vigor, strength and sense of well-being

w anabolic Winstrol combines highest potency* with outstanding grance in an economical oral tablet. Employed adjunctively, its visiotonic benefits are evident in the management of a variety of ients: the geriatric; the post-operative; the weak; the debilitated highering cesses, restores a positive metabolic balance, rebuilds body tissue lie it builds strength, builds confidence and restores a sense of libering.

Usual Adult Dose: I tablet t.i.d. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

Supplied: 2 mg. tablets. Bottles of 100.

because they are stronger!

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

Winthrop

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem.

KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however,

it should be used with care on patients with a predisposition



KOAGAMIN®

parenteral hemostat a. oxalic acid, 2.5 ma. malonic

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer.

Complete dato with each 10cc vial. Theropy chart on request.



halham) CHATHAM PHARMACEUTICALS, INC.

Nework 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontorio

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Avenue, N. E. St. Petersburg, Florida Phone 862-6903



314B John Ringling Blvd Sarasota, Florida Phone 388-1604

> Box 514 Miami 62, Florida Phone 945-4055

Affiliates of Black & Skaggs Associates Battle Creek, Michigan

HCV CREME

3% Iodochlorhydroxyquin

1% Hydrocortisone

Provides ANTIFUNGAL, ANTIBACTE-RIAL, ANTI-INFLAMMATORY AND AN-TIPRURITIC action in dermatitis.

GEVIZOL

Each 5 cc. tspfl or toblet provides 100 mg. Pentylenetetrozol, 50 mg. Nicotinic ocid. GEVIZOL is indicated in the treatment of the mentally confused, emotionally unstable, opothetic aged and aging potient. For the potient complaining of dizziness or fagginess. Reactivates the inactivated.

QUALITY SARON ECONOMY
PHARMACAL

CORPORATION

St. Petersburg

Florida



SOCLOR IIMESULE

LOR TIMESULE CONTAINS:

iramine maleate 10 mg.
Irine HCL 65 mg.
al form providing prolonged



Schematic drawing of Timesule cell wing dialysis gh permeable coating.



A NEW COMPREHENSIVE RELIEF

- Relief usually starts in minutes—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
- Relief usually lasts up to 12 hours with a single oral dose
- Gives both upper respiratory decongestion and bronchodilatation to relieve chest discomfort
- With minimal drowsiness, CNS or pressor stimulation

MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

OOSE: Adults: One Timesule every 12 hours, or as directed.

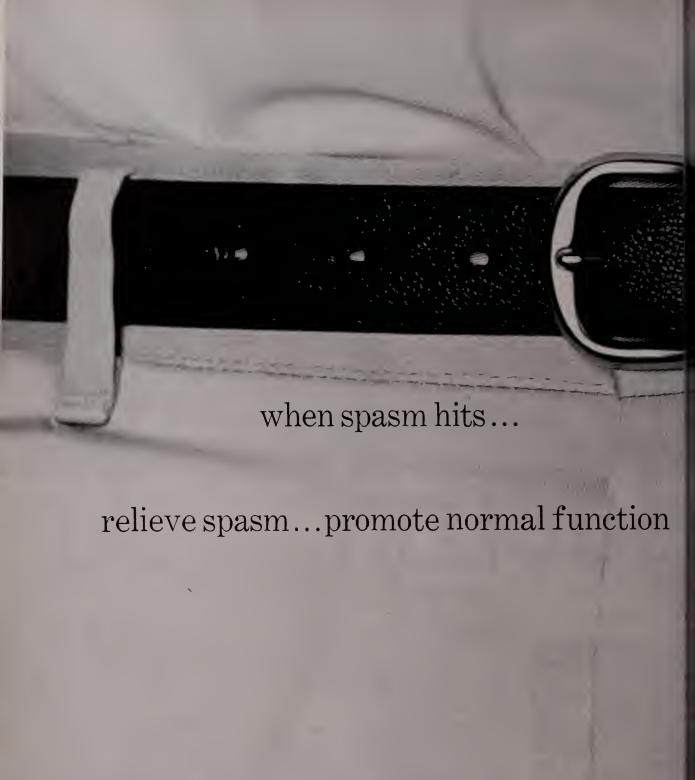
WARNING: Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

Send for Samples and Literature

CHARLES C. HASKELL & COMPANY



Richmond, Virginia





${\it vew PATHILON} {\it `SEQUELS'' with Phenobarbital'}$

TRIDIHEXETHYL CHLORIDE Sustained Release Capsules
Each capsule contains: Tridihexethyl chloride...75 mg.; Phenobarbital...45 mg.

ormulated for controlled release of the active gredients, for sustained anticholinergic proction against spasm and pain in the G.I. tract, well as sustained phenobarbital action.

liminates the necessity for numerous doses; attens out "peaks and valleys" in drug blood vels that can minimize effectiveness; and reases protective medication through the night. ffective in organic and functional disorders the gastrointestinal tract (duodenal ulcer, testinal colic, ileitis, esophageal spasm, testinal spastic colon, alcohol-induced G.I. psets, gastric hypermotility) and anxiety

neurosis with G.I. symptoms. Should be used as an adjunct to other measures. Side Effects due to tridihexethyl chloride: dry mouth, blurring of vision, constipation. Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention. Supply: Bottles of 30 and 500.

Also available: PATHILON SEQUELS (without phenobarbital) Tridihexethyl chloride, 75 mg. Bottles of 30 and 500.



in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® POLYMYXIN B-BAGITRAGIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. Supplied: in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Proctologic Aid

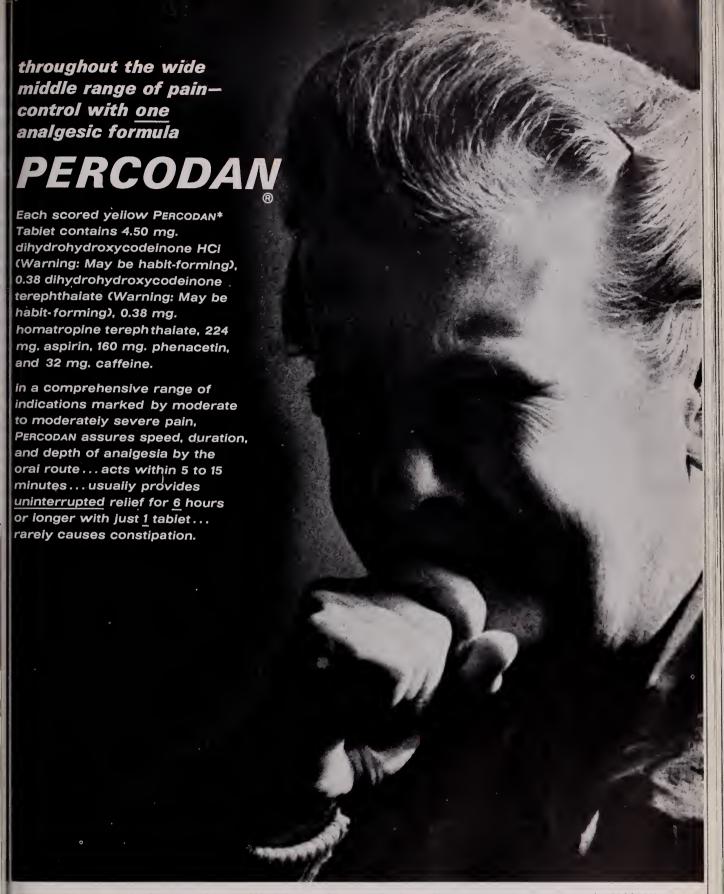
PROCTO-REST is a simple device that provides a full measure of convenience in sigmoidoscopy procedures. It is designed to establish and maintain correct positioning of the patient. Its sturdy construction and formed padding provide comfort and induce relaxation.

Takes only seconds to unfold. Has locking bracket for complete safety. Can be used on any examining table.



Folds compactly for storage. Fits into the base of the examining table or a storage cupboard. Supplied in gray, white or brown upholstery.

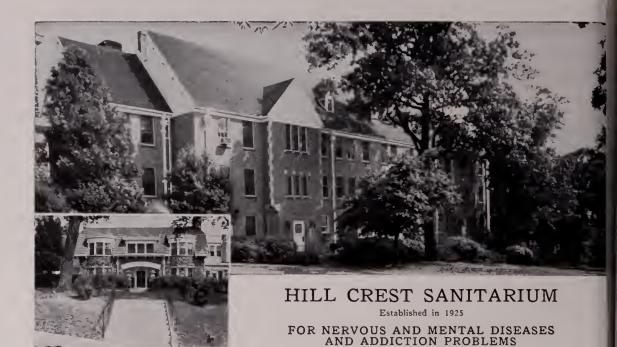




Average Adult Dose—1 tablet every 6 hours. Side Effects and Contraindications—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. Also available: PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxy-

codeinone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. Literature on request.

ENDO LABORATORIES Richmond Hill 18. New York



Out-Patient Clinic and Offices

James A. Becton, M.D.

James Keen Ward, M.D.

P. O. Box 2896, Woodlawn Station, Birmingham 6, Ala. Phone WO 1-1151 and WO 1-1152

APPALACHIAN HALL

ASHEVILLE

Established 1916

NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en

Wm. Ray Griffin Jr., M.D. Robert A. Griffin, M.D. Mark A. Griffin Sr., M.D. Mark A. Griffin Jr., M.D.

For rates and further information write Appalachian Hall, Asheville, N. C.

A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE

4539 Beach Blvd. Telephone FL 9-2191

ORLANDO

1511 Sligh Blvd. Telephone GA 5-3537

CONVENTION PRESS

218 W. CHURCH ST. JACKSONVILLE, FLORIDA

QUALITY
BOOK PRINTING
PUBLICATIONS
BROCHURES

W HATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine quality work—and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders and Invalids Alcoholics Treated



5226 Nichol St. Telephone 61-4191

DON SAVAGE
Owner and Manager

Aged adjudged cases will be accepted on either permanent or temporary basis.

Safety against fire — by Automatic Fire Sprinkling System.

Cyclone fence enclosure for recreation facilities, seventy-five by eighty-five feet.

ACCREDITED
HOSPITAL FOR
NEUROLOGICAL
PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

P. O. Box 10368 Tampa 9, Florida

A special margarine for the atherosclerosis diet

The latest report* in the JAMA on atherosclerosis diets states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

Since this report recognizes table spreads as an important source of dietary fat, we believe that it is in your professional interest to know about the fatty-acid composition of Mrs. Filbert's Corn Oil Margarine.

Mrs. Filbert's Corn Oil Margarine is a special margarine** made from 100% corn oil, over 50% of which retains its liquid characteristics.

Because of its high linoleic content, its ratio of polyunsaturates to saturates is about 1.7 to 1... and equals the highest level available today in *any* corn oil margarine.

Of the total fatty acid content, 28% is cis-cis linoleic acid.

Moreover, when you recommend Mrs. Filbert's Corn Oil Margarine, your patient is assured of receiving unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).

**AMA Council on Foods and Nutrition: Composition of Certain Margarines, JAMA 179:719 (March 3, 1962).



Made from 100% corn oil with liquid corn oil as its major ingredient

For additional information-including detailed listings of component characteristics-please write to us.

J. H. FILBERT, Inc.

BALTIMORE 29, MARYLAND



PRICELESS

Today all around us cut-rate and discount houses
flourish. You can buy glasses from \$7.98 up. coop vision
comes a shade higher. In fact you can't put a price
on vision. Your GUILD OPTICIAN endeavors to place the finest in
eye wear before the public at the lowest possible prices.

Guild of Prescription Opticians of Florida

OBDTRO

for medical management of obesity

OBETROL incorporates the desired action of amphetamines with fewer side reactions reported.

MINIMAL SIDE EFFECTS

"In the cooperative patient, OBETROL was markedly beneficial in producing the desirable weight loss with minimal side effects, even in the case of a high percentage of patients with cardiovascular and other chronic ailments which normally make use of other amphetamines undesirable because of side effects" ¹

WEIGHT REDUCTION EFFECTIVE IN DIFFICULT CASES

"With a daily divided dosage of 30 milligrams of OBETROL we were able to obtain appetite depression without nervous restlessness or insomnia . . .

EFFECTIVE WHERE OTHER AMPHETAMINES FAIL

Twenty six patients who previously had been unable to use other amphetamines in any dosage sufficient to maintain the anorectic effect, responded favorably on this medication. ^{1,3}

Contraindications: OBETROL is relatively contraindicated in hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases, anxiety and hyperexcitability. Habituation may occur with prolonged use. As in the case of all amphetamines, caution should be used in treating patients with these conditions.

Each OBETROL-10 tablet contains:

Methamphetamine Saccharate	2.5 mgm.
Methamphetamine Hydrochloride	_2.5 mgm.
Amphetamine Sulfate	_2.5 mgm.
Dextroamphetamine Sulfate	
(OBETROL-20 tablets contain twice this potency)

Pat.# 2748052.

OBETROL PHARMACEUTICALS

382 Schenck Avenue, Brooklyn 7, N. Y.

¹ Simon, F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, 12:32-37, Jan. 1961.

² Plotz, M.: Modern Management of Obesity, J.A.M.A. 170:1513-t515 (July 25) 1959.

³ Bernstein A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.

REQUEST SAMPLES AND LITERATURE OBETROL PHARMACEUTICALS 382 Schenck Avenue . Brooklyn 7, N. Y.

TUCKER HOSPITAL, INC.

212 West Franklin Street RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological patients. Hospital and out-patient services.

(Organic diseases of the nervous system, psychoneuroses, psychosomatic disorders. mood disturbances, social adjustment problems, involutional reactions and selective psychotic and alcoholic problems.)

DR. JAMES ASA SHIELD Dr. George S. Fultz, Jr.

DR. WEIR M. TUCKER DR. W. FREDERICK YOUNG

Design ... Appearance ... Versatility



Burdick EK-III Dual-Speed Electrocardiograph

The all-new Dual-Speed EK-III sets a new standard in high fidelity electrocardiography for recording the fine details of rapid small deflections. With its sensitive recording system the dual-speed paper drive with 50 mm. per second speed to enlarge the horizontal dimensions of heart complexes becomes highly important. Switch from standard 25 mm. to 50 mm. and back again with no transitional lag.

Special Features:

Simplified top-loading paper drive, single 4-position Amplifier/Record switch, convenient ground indicator, all-new single-tube stylus, jacks for cardioscope and D.C. Input connections, rapid lead selection, standard 50 mm. records, modern, clean design. Without sacrificing quality or utility, the EK-III unit is compact and weighs only 221/2 pounds. Call or write us for full details; and if you wish we will be glad to demonstrate the EK-III in your office.

Anderson Surgical Supply Co.

ESTABLISHED 1916

Phone CHerry 1-9589 1616 N. Orange Ave. Orlando

Phone 896-3107 556 9th St. S. St. Petersburg

Phone 229-8504 Morgan at Platt Tampa

Phone 376-8253 729 S.W. 4th Ave. Gainesville



in chronic bronchitis and emphysema ISUPREL® BRAND OF ISOPROTERENOL hydrochloride

MISTOMETER® Q.I.D.

ISUPREL (isoproterenol/Winthrop) "...can increase breathing efficiency in pulmonary emphysema." The patient with chronic obstructive pulmonary disease "...should use the bronchodilator four times daily whether or not he experiences episodes of bronchospasm."

Use of the Mistometer eases breathing by relaxing bronchospasm, and aiding productive cough. "Of the aerosol bronchodilators, ISU-PREL (isoproterenol/Winthrop) seems to be the best...." Conscientious use q.i.d. improves vital capacity and exercise tolerance.

The Mistometer brings new efficacy and convenience – enables patients to maintain treatment wherever they are.

With use of ISUPREL (isoproterenol/Winthrop), occasionally tachycardia, palpitation, nervousness, nausea and vomiting or headache may occur, especially with excessive dosage. Adjust dosage carefully in patients with hyperthyroidism, acute coronary disease, cardiac asthma or limited cardiac reserve, and in persons sensitive to sympathomimetic amines.

Caution: Epinephrine should not be administered with ISUPREL (isoproterenol/Winthrop) as both drugs are direct cardiac stimulants and their combined effects may induce serious arrhythmia. If desired they may, however, be alternated, provided an interval of at least four hours has elapsed.

Dosage: Two inhalations at least one minute apart four times daily, regularly. Inhalations may be taken more often if indicated.

Available as ISUPREL HCI (isoproterenol HCI/Winthrop) Mistometer—single unit combining plastic nebulizer and ISUPREL (isoproterenol/Winthrop) solution 1:400—or 0.25 per cent w/w (=2.8 mg. per ml.), and includes

alcohol, 33 per cent; bottles of 15 ml.

1. Reeves, J. E.: M. Times 90:512, May, 1962. 2. Williams, M. H., Jr.: M. Sc. 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: J. Kansas M. Soc. 56:486, Sept., 1955.



Winthrop Laboratories, New York 18, N.Y.

Winthrop

BRAWNER HOSPITAL, INC.

(Established 1910)

2932 South Atlanta Road, Smyrna, Georgia

FOR THE TREATMENT OF PSYCHIATRIC ILLNESSES AND PROBLEMS OF ADDICTION MODERN FACILITIES

JAS. N. BRAWNER, JR., M.D.

Medical Director

ALOYSIUS I. MILLER, M.D. MARK A. GOULD, M.D.

Phone HEmlock 5-4486



P. L. DODGE MEMORIAL HOSPITAL

formerly

MIAMI MEDICAL CENTER

M. G. ISAACSON, M.D. Medical Director and President

1861 N.W. South River Drive Phone 379-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including — Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities.

Information on request Member NAPPH and American Psychiatric Assn.

A Hospital Using
the Modern Concepts of
Intensive Psychiatric
Treatment
Owned and Operated
by the
Anclote Manor Foundation
A Non-Profit Organization

MEDICAL DIRECTOR Lorant Forizs, M.D.

CLINICAL DIRECTOR
Walter H. Wellbarn, Jr., M.D.

DIRECTOR OF TRAINING Theodare H. Gagliano, M.D.

STAFF PSYCHIATRISTS Rabert G. Zeitler, M.D. Richard L. Meedaws, M.D. Chas. J. Saparito, M.D.

ADMINISTRATOR Fred P. Ryder, M.H.A.

ANCLOTE MANOR



The haspital is oriented far Individual Psychatherapy, Graup Psychatherapy, Therapeutic Cammunity, all Samatic Therapies. The large staff is trained far Team Approach. Recreation by prescription.

SAMUEL G. HIBBS, M.D., F.A.P.A.

President of the Board Chief Consultant in Psychiatry

Consultants in Psychiatry
Walter H. Bailey, M.D., F.A.P.A.
Arturo Gonzalez, M.D.
Saul C. Holtzman, M.D.
Alfred D. Koenig, M.D.
Martha W. MacDonald, M.D.
Roger E. Phillips, M.D.
Zack Russ, Jr., M.D., F.A.P.A
Peter J. Spoto, M.D.
Robert G. Steele, M.D.
Samuel G. Warsan, M.D., F.A.P.A.

Member Notional Association of Private Psychiatric Haspitals,
American Haspital Association, Florida Haspital Association.
Approved by American Psychiatric Association, Accredited by Jaint Cammission on Accreditation of Hospitals.

Located at TARPON SPRINGS, Florida — Phone: 937-4211



Brightens mood ... relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

'Deprol'

meprobamate 400 mg. + benactyzine 1 mg.

WALLACE LABORATORIES / Cranbury, N.J.





all things considered...the decision is for

in otitis media, having weighed the c cal considerations basic to management, physicoften choose DECLOMYCIN demethylchlort cycline for broad-spectrum antibiotic their DECLOMYCIN demethylchlortetracycline proactivity levels higher than do other tetracycline at lower dosage...and maintains them wit significant fluctuation.

Activity is prolonged 24 to 48 hours after the









DECLOYICINE SUPERIOR SUPERIOR

e, thus helps protect against relapse-an "extra ension" in broad-spectrum control.

ffective in a wide range of everyday infectionsiratory, urinary tract and others-in the young aged-the acutely or chronically ill-when the nding organisms are tetracycline-sensitive. Side ects typical of tetracyclines which may occur: sitis, stomatitis, proctitis, nausea, diarrhea, vagi-, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction.

Syrup, 75 mg. demethylchlortetracycline/5 cc. and Pediatric Drops, 60 mg./cc.

Average Daily Dosage-Infants and Children: 3 to 6 mg. per lb. body weight, in 2 or 4 doses.

ERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York (Lederle)



FLORIDA MEDICAL ASSOCIATION

735 Riverside Ave., P. O. Box 2411 Jacksonville 3, Florida

Officers

WARREN W. QUILLIAN, M.D., President	Coral Gables
SAMUEL M. DAY, M.D., President-Elect	
H. PHILLIP HAMPTON, M.D., Vice President	
EUGENE G. PEEK JR., M.D., Speaker of the House	
FRANKLIN J. EVANS, M.D., Vice Speaker	
FLOYD K. HURT, M.D., Secretary-Treasurer	
ROBERT E. ZELLNER, M.D., Immediate Past President	
W. HAROLD PARHAM, Executive Director	Jacksonville

Councils

THOMAS C. KENASTON SR., M.D., Chairman, Council on Allied Professions and Vocations	
JERE W. ANNIS, M.D., Chairman, Judicial Council	Lakeland
H. PHILLIP HAMPTON, M.D., Chairman, Council on Legislation and Public Agencies	Tampa
BURNS A. DOBBINS JR., M.D., Chairman, Council on Medical Economics	Fort Lauderdale
HUGH A. CARITHERS JR., M.D., Chairman, Council on Medical Education and Hospitals	Jacksonville
CHARLES R. SIAS, M.D., Chairman, Council on Medical Services	Orlando
THAD MOSELEY, M.D., Chairman, Scientific Council	Jacksonville
WALTER C. PAYNE SR., M.D., Chairman, Council on Special Activities	Pensacola
EMMET F. FERGUSON JR., M.D., Chairman, Council on Specialty Medicine	Jacksonville
MASON ROMAINE III, M.D., Chairman, Council on Voluntary Health Agencies	Jacksonville

INDEX TO ADVERTISERS

American Fracture Association	226	•Lederle Laboratories	238
• American Tobacco Co.	184	239, 252,	25.
• Ames Co., Inc.	Third Cover	• Eli Lilly & Co	19-
• Anclote Manor	250	Medical Protective Co	
• Anderson Surgical Supply Co.	248	Medical Supply Co	24
• Appalachian Hall	242	Obetrol Pharmaceuticals	
Arnar-Stone Laboratories	237	Parke Davis & Co Second Cover,	179
Ballast Point Manor	244	• P. L. Dodge Memorial Hospital	250
Brawner Hospital, Inc	250	• PM of Florida	
Brown Pharmaceutical Co	234	• A. H. Robins Co., Inc.	18.
Burroughs Wellcome & Co	187, 240	• Roche Laboratories Back C	
Chatham Pharmaceuticals, Inc.	236	• William H. Rorer, Inc.	
• Convention Press	244	Saron Pharmacal Corp.	
Davies, Rose & Co.	243	• G. D. Searle Company	
• Duvall Home		• Silver Hill Foundation	
• Dynatomics, Inc.		• Smith, Kline & French	
• Endo Laboratories		• E. R. Squibb & Sons	
J. H. Filbert, Inc.		• Surgical Supply Co.	
		• Tucker Hospital, Inc.	
• Glenbrook Laboratories		• U. S. Vitamin & Pharmaceutical Corp. 228,	
• Guild of Prescription Opticians		• Wallace Laboratories 192, 227, 230, 232,	
Hill Crest Sanitarium	242	• Winthrop Laboratories 180, 185, 235,	249



Library
New York Acalemy of Telicine
2 East 103rd St
New York 29 N Y J 12-63



specific for anxiety and tension

LIBRIUM (chlordiazepoxide HCI)

Dosage: Oral - Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or 4 times daily. Side Effects: Oral - Drowsiness and ataxia, usually dose-related, have been reported in some patients-particularly the elderly and debilitated. Paradoxical reactions, i.e., excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions may be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other side effects, usually dose-related, have included isolated instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. Precautions: Oral-In elderly, debilitated patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to be increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Caution patients about possible combined effects with alcohol. Caution should be exercised in administering Librium (chlordiazepoxide HCI) to addictionprone individuals. Careful consideration should be given to the pharmacology of any agents to be employed concomitantly-particularly the MAO inhibitors and phenothiazines. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. Caution should be exercised in prescribing any therapeutic agent to pregnant patients.

October, 1963

The JOURNAL of the Florida Medical Association

HYPERKINETIC DISORDERS

CICATRICIAL LARYNGEAL STENOSIS

CUTANEOUS MALIGNANT MELANOMA,

VAGINAL HYSTERECTOMY

DIABETES AS A HEALTH PROBLEM

INDICATIONS FOR NECK DISSECTION

MEDICAL PROCLATION

PLORIDA

MEDICAL PROCLATION

Helps the epileptic to realize his potential

DILANTIN (DIPHENYLHYDANTOIN SODIUM)



he most effective form of emotional approach remains the demonstraon to the patient that the seizure phenomena can be adequately conolled with anticonvulsant medication."

present, diphenylhydantoin sodium is generally regarded as the standd in anticonvulsant medication because of its effectiveness in controlig grand mal and psychomotor seizures.2-10 It possesses a wide margin safety, and incidence of side effects is minimal.4 With this agent, ersedation is not a problem.3 Moreover, its use is often accompanied improvement in the patient's memory, intellectual performance, and notional stability.11

lications: Grand mal epilepsy and certain other convulsive states.

ecautions: Toxic effects are infrequent: allergic phenomena such as lyarthropathy, fever, skin eruptions, and acute generalized morbillim eruptions with or without fever. Rarely, dermatitis goes on to foliation with hepatitis, and further dosage is contraindicated. Eruptions an usually subside. Though mild and rarely an indication for stopping sage, gingival hypertrophy, hirsutism, and excessive motor activity are casionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia has been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

DILANTIN Sodium (diphenylhydantoin sodium) is available in several forms including Kapseals,® 0.03 Gm. and 0.1 Gm., bottles of 10Q and 1,000.

REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. 8:448, 1958. (2) Roseman, E.: Neurology 11:912, 1961. (3) Bray, P. F.: Pediatrics 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.; M. Clin: North America 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) Ibid. Postgrad. Med. 20:554, 1956. (8) Merritt, H. H.; Brit. M. J. 1:666, 1958. (9) Carter, C. H.: Arch. Neurol & Psychiat. 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.





in chronic bronchitis and emphysema ISUPREL® BRAND OF ISOPROTERENOL

nydrochloride

hydrochloride

MISTOMETER® Q.I.D.

ISUPREL (isoproterenol/Winthrop) "...can increase breathing efficiency in pulmonary emphysema." The patient with chronic obstructive pulmonary disease "...should use the bronchodilator four times daily whether or not he experiences episodes of bronchospasm."

Use of the Mistometer eases breathing by relaxing bronchospasm, and aiding productive cough. "Of the aerosol bronchodilators, ISU-PREL (isoproterenol/Winthrop) seems to be the best...."³ Conscientious use q.i.d. improves vital capacity and exercise tolerance.

The Mistometer brings new efficacy and convenience – enables patients to maintain treatment wherever they are.

With use of ISUPREL (isoproterenol/Winthrop), occasionally tachycardia, palpitation, nervousness, nausea and vomiting or headache may occur, especially with excessive dosage. Adjust dosage carefully in patients with hyperthyroidism, acute coronary disease, cardiac asthma or limited cardiac reserve, and in persons sensitive to sympathomimetic amines.

Caution: Epinephrine should not be administered with ISUPREL (isoproterenol/Winthrop) as both drugs are direct cardiac stimulants and their combined effects may induce serious arrhythmia. If desired they may, however, be alternated, provided an interval of at least four hours has elapsed.

Dosage: Two inhalations at least one minute apart four times daily, regularly. Inhalations may be taken more often if indicated.

Available as ISUPREL HCI (isoproterenol HCI/Winthrop) Mistometer—single unit combining plastic nebulizer and ISUPREL (isoproterenol/Winthrop) solution 1:400—or 0.25 per cent w/w (=2.8 mg. per ml.), and includes

alcohol, 33 per cent; bottles of 15 ml.

1. Reeves, J. E.: M. Times 90:512, May, 1962. 2. Williams, M. H., Jr.: M. Sc. 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: J. Kansas M. Soc. 56:486, Sept., 1955.

Winthrop Laboratories, New York 18, N.Y.



Winthrop

The JOURNAL

of the Florida Medical Association

Volume 50, Number 4, October, 1963

THIS ISSUE

THAD MOSELEY, M.D.

SHALER RICHARDSON, M.D. Editor Emeritus

Assistant Editors

CHARLES K. DONEGAN, M.D. FRANZ H. STEWART, M.D. JOHN M. PACKARD, M.D.

THOMAS R. JARVIS
Managing Editor

Louise Rader
Assistant
Managing Editor

EDITH B. HILL Editorial Consultant

Published monthly at Jacksonville, Florida. Price \$7.00 a year: single numbers, 70 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville, Fla., 32203. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103. Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Articles

Surgical Treatment of Hyperkinetic Disorders, Irwin	
Perlmutter, M.D., and David Fairman, M.D.	275
Cicatricial Laryngeal Stenosis, James C. Garlington, M.D.,	
and George T. Singleton, M.D.	277
Early Recognition of Cutaneous Malignant Melanoma in	
Adults, Tobias R. Funt, M.D.	280
Vaginal Hysterectomy After Previous Surgery, Howard C.	
Duckett, M.D., and J. B. Williams Jr., M.D.	282
Diabetes as a Health Problem in Florida,	
James E. Fulghum, M.D.	284

Editorials

Surgical Treatment of Parkinsonism and Other Hyperkinetic	
Disorders, John A. Broward, M.D.	289
Ethics and the Medical Profession, Franklin J. Evans, M.D.	290
To Refill or Not to Refill, B. S. Rogers	291

Features

Surgery Page	
Indications for Neck Dissection, John J. Fomon, M.D.	286
President's Page	287
Association News	292
Clinical Comment	295
Deaths	297
Meetings	298
Books Received	298
News	302
Classified	304
Florida Medical Association Officers and Council Chairmen	334

This Journal is not responsible for the opinions and statements of its contributors. Owned and published by the Florida Medical Association.

cut Rx writing by 2/3 in colds, flu or grippe

NAME

ADDRESS

R

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct...

economically sound...to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC 'EMPRAZIL-C'TABLETS

Each tablet contains:

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcy-clizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. Supplied: Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML. BURROUGHS WELLCOME & CO (U.S.A.) INC.

Tuckahoe, N. Y.

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin, brand of dipyridamole

See next 3 pages

Study 1.

Griep, A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:

A Report of Fifty Cases. Angiology 14:484, 1963.

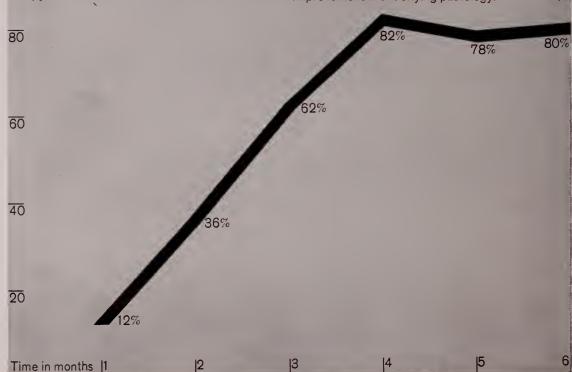
Persantin, brand of dipyridamole, 25 mg. t.i.d. or q.i.d., was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis; final evaluation after 6 months showed that 56% of patients were completely free of, or had markedly fewer, anginal attacks, with normal or improved ECG findings; an additional 24% experienced fewer, milder attacks and improved work capacity.

Persantin[®]

brand of dipyridamole

"..long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients... relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"

% of patients responding each month to dipyridamole Steady, month-by-month improvement with Persantin, brand of dipyridamole, refutes possibility of "placebo response", reflects gradual improvement in underlying pathology.



Study 2.

Wirecki,M.: Dipyridamole (Persantin*): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

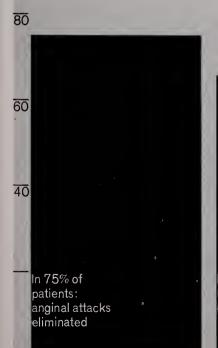
In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin, brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

Results after 3 months of therapy revealed a satisfactory clinical response in 32 patients. The accompanying diagram illustrates the specific criteria of improvement in patients with excellent or good response.

Of 40 patients, 32 showed...reduction or abolition of acute anginal attacks...complete or almost complete disappearance of ECG abnormalities... marked increase" in walking distance without anginal symptoms

Response after 3 months of continuous therapy with Persantin® brand of dipyridamole

% of patients







How Persantin; brand of dipyridamole, provides long-term clinical benefits reported on previous pages

1. By increasing energy yield

of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).¹⁻⁵

2. By improving collateral coronary circulation.

Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls. 6-9

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:

Tablets of 25 mg., bottles of 100 and 1000. Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin, brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess, M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.27:849,1962.



Geigy Pharmaceuticals Division of Geigy Chemical Corporation Ardsley, New York, Distributors

PE-2254

THE FIRST OBJECTIVE IN RELIEVING SINUS HEADACHE IS A PATENT PATIENT

The second, of course, is relieving the headache. Headache gone, sinus clear. The patent patient may not know it, but his sinus headache disappeared because in addition to analgesia, the tablet he took also relieved congestion. That's how Ursinus works.

Each Inlay-Tab® contains the completely soluble analgesic Calurin® (brand of calcium carbaspirin) equivalent to 300 mg. aspirin, plus the time-tested decongestant Triaminic® 50 mg. (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.). Use with caution in presence of hypertension, heart disease, diabetes, or thyrotoxicosis. If drowsiness occurs, patient should not engage in activities requiring maximum alertness. Usual dose is one Inlay-Tab four times a day.HEADACHE GONE, SINUS CLEAR.

HAVE YOU TRIED URSINUS YET?

DORSEY LABORATORIES • a division of The Wander Company • LINCOLN, NEBRASKA

267



Gevrabon

Geriatric Vitamin-Mineral Supplement Lederle

Sherry-flavored GEVRABON provides a palatable means of maintaining good nutritional levels of vitamins. Suggested serving: as an apéritif, pour GEVRABON over ice cubes and take before a meal. The comprehensive formula in a light liquid vehicle is particularly appropriate for geriatric patients.

Each fluid ounce (30 cc.) contains: Vitamin B_1 , 5 mg.; Vitamin B_2 , 2.5 mg.; Vitamin B_6 , 1 mg.; Vitamin B_{12} , 1 mcgm.; Niacinamide, 50 mg.; Inositol, 100 mg.; Choline, 100 mg.; Pantothenic Acid, 10 mg.; Potassium, 10 mg.; Zinc, 2 mg.; lodine, 0.1 mg.; Magnesium, 2 mg.; Manganese, 2 mg.; Calcium, 48 mg.; Phosphorus, 39 mg.; Iron, 20 mg.; Alcohol, 18%. DOSAGE: 2 tablespoonfuls (30 cc.) daily.





LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

Announcing a valuable new aid for all who treat young patients

Up-to-date help for your research and for your evaluation of other's work

A New Book! CURRENT PEDIATRIC THERAPY Edited by Gellis and Kagan

This entirely new book, Current Pediatric Therapy, will enable you to enjoy the same type of specific therapeutic recommendations for your young patients that readers of Current Therapy have been receiving for some fifteen years. Dr. Sydney S. Gellis and Dr. Benjamin M. Kagan have edited this new work, with contributions by over 200 leading authorities. Therapeutic details are pinpointed for more than 300 diseases—from Kwashiorkor and Protein Deficiency to Infantile Cortical Hyperostosis, and Prematurity. All the diseases and disorders in this book are treated in terms of how they afflict infants and children. Since this book equals Current Therapy in size, you can see how valuable this comprehensive text can be in this area of your practice.

All discussions are approached from the pediatric point of view, with dosages, diets, prescriptions, etc., written for infants and children. This new Current Pediatric Therapy concentrates on giving you the best treatments available today as they are currently being used by specialists with wide experience in specific areas. You will not find involved discussions of diagnosis and etiology here—just concise, clearly delineated details on the best treatments for virtually all the diseases and disorders you will be called upon to manage in your child patients.

Whether you need a diet for a phenylketonuric child, help on deciding the proper dosage of antiepileptic medication, or late information on immunization schedules, you'll find it spelled out precisely in *Current Pediatric* Therapy.

By 224 Leading Authorities. Edited by Sydney S. Gellis, M.D., Professor of Pediatries, Boston University School of Medicine; Director of Pediatrics, Boston City Hospital; and Benjamin M. Kagan, M.D., Director of Pediatrics, Cedars of Lebanon Hospital, Los Angeles, About 864 pages, 7-7/8" x 10-7/16". About \$16.00. New—Ready January!

New (2nd) Edition! Mainland's ELEMENTARY MEDICAL STATISTICS

Here is an enlarged and improved New (2nd) Edition of one of the most respected American texts on medical statistics. Dr. Mainland has devoted the first ten chapters to expanded discussions on statistical thinking, rather than arithmetic. These beginning chapters are in the form of questions which you can ask yourself regarding your own research, and which you can apply to evaluation of the work of others. Each question is the basis for an explanatory discussion. In this section vou'll find vital information on: the nature of the research; purpose and general method of investigation; the population and sampling; interpretation; sample sizes; collecting and examining data. Next, specific methods of analysis are presented and discussed. Chief attention is paid to methods a small scale investigator would use. In this latter portion of the book you'll find such topics as: random processes; standard deviation; frequency distribution of measurements; causes of bellshaped distribution; estimation of population percentiles; correlation coefficients, etc.

By DONALD MAINLAND, M.B., Ch.B., D.Sc., Professor and Chairman, Department of Medical Statistics, New York University College of Medicine. 381 pages, 6\%" x 9\%", illustrated. About \$9.00.

New (2nd) Edition- Just Ready!

To Order Mail Coupon Below!

W.	В.	SA	UN	DER	es c	20	MP	ANY
Wes	t Wa	shin	gton S	Squar	e, Phi	lade	lphia	5, Pa.
Pleas	se sen	d wl	ien rea	ady an	d bill	me:		
\Box C	urren	t Pe	diatric	Ther	apy		About	\$16.00
□ M				entary tics			.Abou	ıt \$9. 00
Name	e							
Addr	ess							
							S	JG 10-63



For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin® Antacid Tablets

"...faster in onset of action...and for a longer period"*

"Clinical studies in 85 patients with duodenal ulcer...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. It does not cause constipation.

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity-from 2 to 4 tablets as needed. Peptic ulcer or gastritis-from 2 to 4 tablets every two to four hours. How Supplied: Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

Sehwartz, I. R .:

Current Therap. Res. 3:29, Feb., 1961.



For your elderly arthritic patients

AN EFFECTIVE

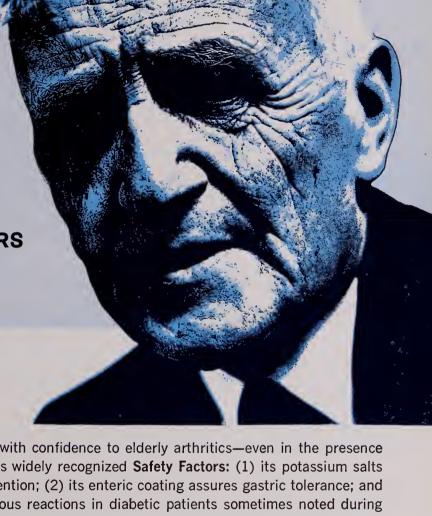
GERIATRIC

ANTIARTHRITIC

WITH ESSENTIAL



safely indicated
- even in
the presence of
HYPERGLYCEMIA



PABALATE-SF may be prescribed with confidence to elderly arthritics—even in the presence of hyperglycemia—because of its widely recognized **Safety Factors**: (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) its use is free from the serious reactions in diabetic patients sometimes noted during therapy with steroids or pyrazolone derivatives. As for effectiveness, it has been found "superior to aspirin in the treatment of chronic rheumatic disorders."

Each persian-rose enteric-coated tablet contains: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

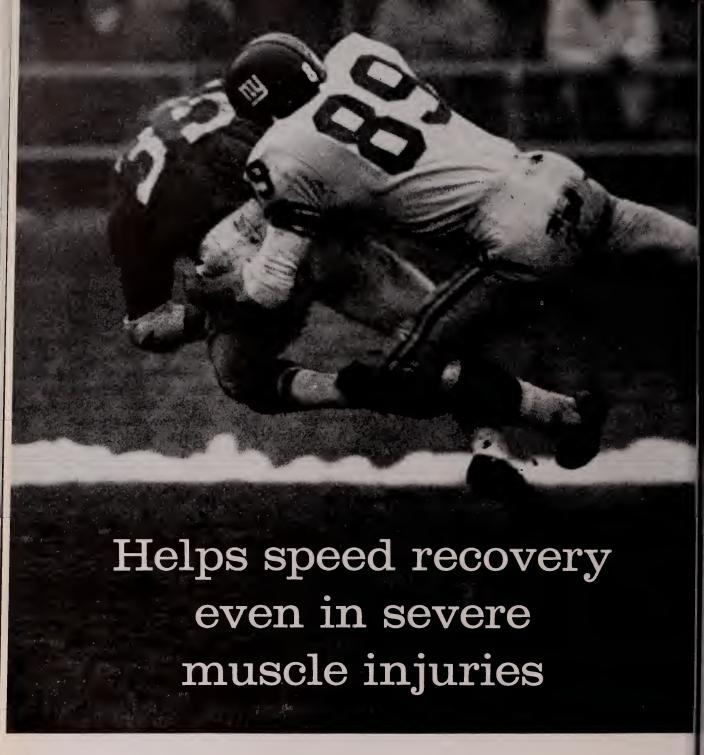
1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal

impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.



(the new, convenient way to prescribe Pabalate-Sodium Free)



Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. (Clinical Medicine, March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely. For severe athletic strains or everyday sprains,

you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.C

The muscle relaxant with an independent pain-relieving action



59,

Wallace Laboratories, Cranbury, New Jersey



Your recommendation of **Coricidin** assures responsible treatment of common colds. For added decongestant action, recommend Coricidin "D" Decongestant Tablets.



Each CORICIDIN Tablet contains: CHLOR-TRIMETON® (chlorphen-Iramine maleate, Schering) 2 mg., aspirin 0.23 Gm., phenacetin 0.16 Gm., caffeine 0.03 Gm. Each CORICIDIN "D" Tablet contains phenylephrine 10 mg. in addition to the above ingredients.

CORICIDIN Tablets, brand of antihista-minic-antipyretic-analgesic compound



This is the key that opens the box that contains the labels. Only authorized supervisory personnel have the key to transfer labels from the "lockup box" to the labeling machine.

These responsible Lilly employees regard labels as serious business. To make certain that the right label appears on each container, all labels are kept under lock and key until needed on the finishing line. Only the quantity needed to

finish the lot is dispensed. When transferred to the finishing belt, the appropriate number of labels is placed in the labeling machine. Excess labels are put in the lockup box until needed. At night, the supervisor returns unused labels to the box lest some get lost or misplaced. This is just one more precaution in an endless list of rules that contribute immeasurably to the quality of the finished product.

The JOURNAL

of the Florida Medical Association

Surgical Treatment of Hyperkinetic Disorders

Parkinsonism, Cerebral Palsy, Dystonia, Cerebellar Tremor

IRWIN PERLMUTTER, M.D.
AND DAVID FAIRMAN, M.D.
CORAL GABLES

In an article entitled "Surgical Treatment of Parkinsonism" a series of patients with hyperkinetic disorders operated on by us was reported in the February 1961 issue of The Journal. By January 1963, 104 patients had been followed postoperatively for from six months to five years. Eighty of them had parkinsonism, 23 had athetoid or dystonic conditions, and one had bilateral cerebellar degenerative disease with a wild intention tremor.

It is well known that in order to place a lesion in the basal ganglia accurately, one must employ some sort of three dimensionally oriented apparatus. To do otherwise would be to deny the accuracy of the Norden bomb sight employed by the military establishment and advocate a return to World War I methods. The Horsley-Clarke device, so useful in monkeys, has been modified by Spiegel and Wycis in Philadelphia, and similar equipment has been employed by others. These devices and their methods of application are quite complicated and time-consuming.

Method

The stereotactic technique that we use is a relatively simple one which employs a device that attaches to the skull at a single trephine hole. The technical details of the apparatus and method were described by one of us (D.F.) in an article entitled "Roentgenological Principles of New Stereotactic Apparatus" in the American Journal of Roentgenology, June 1959.

Discussion

In spite of the great accuracy obtained with stereotactic localization, which has a margin of error from 0.5 to 1.0 mm., there are other anatomic problems met in the brain. Not the least important of these is that of individual variation. Most systems use the foramen of Monro, the pineal body and the commissures as reference points and relate these to other intracerebral structures. Unfortunately, these points of reference are not in absolute relationship to themselves or to basal gangliar masses. Many investigators therefore seek physiological confirmation of the electrode placement.

When the patient is awake during the operation, as most patients with parkinsonism are, the simple insertion of the electrode produces immediate relief, to a greater or lesser degree, of the rigidity the moment the target is reached. Tremor, which frequently disappears or is markedly damped pari passu with rigidity is, it is believed, not an accurate criterion for localization because of the very important role played by the so-called

"emotional components" in the hyperkinetic disorders. The increase or decrease of spontaneous motor activity such as tremor or rigidity following stimulation of basal gangliar structures is not a reliable sign of the accuracy of the electrode placement because of the variability of the response.

When the patient is under general anesthesia, as most of the patients with athetoid and dystonic conditions must necessarily be, stimulation is carried out as soon as the electrode has been placed and the position of its tip verified by x-ray. When the physiological tests confirm both positively and negatively that the position of the electrode is at the target and not in or too near the internal capsule, the lesion is made. The size and shape of the lesion are visualized by injecting a few drops of Pantopaque through the specially cannulated electrode.

The average time for the operation, including the pneumoencephalogram, is between one and a half and two hours. The average time of hospitalization of the patient is five days.

Results

Patients up to 74 years of age have been operated on successfully. Results have been satisfactory in 90 per cent of these patients, with partial or complete relief of the hyperkinesia. The degree and type of benefit to the patient have been in relation to the stage of development and type of the previously existing syndrome and to the entire constellation of signs and symptoms in each patient. There were no operative deaths, and hemiplegia did not occur in this series. In most of the patients an accurately placed lesion was made with a single electrode insertion.

Report of Cases

Case 1.—A 52 year old, right-handed housewife with bilateral severe, totally incapacitating parkinsonism was first examined by us on July 7, 1959, at the request of Dr. Julius R. Pearson. Fourteen years earlier her left arm began to tremble and be "tight;" then the left leg became involved. This tremor and rigidity next involved the right-sided extremities. By the time she was seen, she could not dress or feed herself. She was not able to walk, She could not bathe herself. She had frequent "spasms" in her arms and legs. She was confined to her bed or to a wheel chair. She was depressed all the time and cricd a great deal. She had an emotionless facial expression.

On Oct. 12, 1959, a right-sided chemopallidectomy was performed by the Fairman stereotactic technique. Marked relief of the tremor and rigidity of the left-sided extremities followed. In June 1961 a left electrothalamotomy was performed by the Fairman stereotactic technique. Since that time improvement has been dramatic and progressive. When the patient was last examined in October 1962, she had no tremor of the right-sided extremities and no rigidity of this side. She had a slight tremor still and very mild rigidity of the left-sided extremities. She does all her housework and shopping.

She sews, writes letters, and according to her husband, "leads a normal physical life." According to him, "she has a very relaxed expression and smiles readily, and the emotions are expressed in her face almost as well as before she got sick."

Case 2.—A 33 year old, right-handed man, who had had severe writhing and athetoid movements of an almost completely disabling degree since early childhood, was referred by the Florida State Vocational Rehabilitation Commission. He began to have "convulsions" at the age of seven, followed in a few weeks by abnormal involuntary movements which had been present ever since.

When first examined by us on April 30, 1958, he had a severe hyperkinetic syndrome characterized by irregular and violent movements of both upper extremities, more severe on the left side. The legs were involved in the hyperkinesia as well, but less severely than the arms. The most important component of these movements was of an athetoid "writhing" type. The head and neck were involved in a fluctuating spasmodically writhing type of torticollis with a more frequent flexion and rotation to the left.

His mentality appeared grossly normal. He could, however, perform no useful functions. He walked only with help from his mother.

Right chemopallidectomy was performed on July 2, 1958, at the Doctors' Hospital in Coral Gables, with employment of the Fairman stereotactic technique. Since that time he has improved markedly and progressively. By May of the following year he had improved so greatly that his proficiency at golf was rewarded by a feature story of him in his home town newspaper, complete with photographs of his "classic" style. He repaired household furniture. He walked for miles without assistance. He mowed the lawn and drove the car.

When he was last examined on Oct. 17, 1962, the improvement had not only been sustained but heightened. The abnormal involuntary movements of the left-sided extremities were minimal. These extremities had normal strength and were useful. Because of the highly satisfactory degree of general improvement that he has experienced, consideration of electrotha'amotomy on the left

side has been postponed.

Case 3.—A 67 year old, right-handed man with marked progressive degenerative cerebellar disease bilaterally was first examined by us on Jan. 10, 1962. He complained of a completely disabling, wild, intention tremor of both upper extremities. This difficulty had begun about 20 years previously and from his history was probably related to excessive ethanol intake. Only during the past two years had the tremor become so incapacitating that he was unable to perform his duties as a pastry chef at an exclusive club. He was allowed to remain on a job that required only gross activities, by the grace of a kindly club directorate.

On June 15, 1962, at the Doctors' Hospital in Coral Gables, an electrothalamotomy, performed by the Fairman stereotactic technique, was carried out on the left side. Since that time he has progressively improved. He says he is 80 per cent improved as far as the tremor of the right-sided extremities is concerned. He is back at work at his old job of pastry chef. He is able to place candles on the cakes he bakes. He is able to drink water out of a normal-sized glass. He uses a tablespoon to drink his soup and stated on Oct, 10, 1962, that he performed his job as well as he had 10 years previously.

It is of interest that our secretary meets this patient at a cafeteria near where they live on an average of once every few weeks. She reports that he is at work full time at his regular job and is delighted with the results of the

operation.

Conclusion

The results obtained, it is believed, are due to the care taken in patient selection and to the accuracy of the stereotactic technique employed. 4685 Ponce de Leon Boulevard.

Cicatricial Laryngeal Stenosis

JAMES C. GARLINGTON, M.D.* AND GEORGE T. SINGLETON, M.D.** GAINESVILLE

Cicatricial larvngeal stenosis results from a variety of causes. Today, the prime etiology is blunt laryngeal trauma. This is frequently sustained at the time of automobile accidents. All too often, laryngeal injury is not suspected unless airway insufficiency or an open wound of the neck calls attention to this area.1 As pointed out by Jackson,² high tracheostomies rather regularly culminate in laryngeal stenosis. Infections and x-irradiation not infrequently result in cicatricial laryngeal stenosis.

Correction of cicatricial stenosis of the larynx usually involves multistaged operations and it heavily taxes the resources, patience, and ingenuity of both the physician and the patient. Results of therapy are often less gratifying than are desired by all concerned. "Rehabilitation of the patient with chronic laryngeal stenosis has three requisites: First, re-establishment of the normal airway and closure of the tracheostomy; second, the restoration of as serviceable a voice as possible, and aiding the patient in overcoming the embarrassment of what is frequently exceedingly abnormal speech; third, to provide a larynx that will close satisfactorily to prevent the aspiration of food and fluid during deglutition."3

Modern treatment of cicatricial laryngeal stenosis began with Schmiegelow⁴ in 1929 when he advocated removal of the laryngeal scar tissue and stenting of the injured larynx with open gum rubber tubes. The stents were anchored in the larynx by through-and-through silver wires and were left for varying periods of time. In 1930, Arbuckle⁵ combined Schmiegelow's method of treatment with split thickness skin grafting of the raw laryngeal surface. Thus, by 1930, the basic concepts of reconstructive surgery for cicatricial laryngeal stenosis had been formulated.

Since then there have been numerous modifications of obturators,3,6,7 types of grafts,8 and surgical techniques. At the present time either acrylic or soft plastic obturators are preferred. Acrylic obturators can be anchored around the tracheostomy tube, or they may be secured by

heavy silk strings which pass out through the tracheostomy and are tied around the neck. Soft plastic obturators may be anchored by silk strings, or a distal flange may be led out through the tracheostomy stoma and may be secured there. Originally it was recommended that the obturator be left in place from two to four weeks. Now it is recommended that the obturator be indwelling for at least six months to minimize contracture after it is removed. In addition to split thickness skin, buccal and vaginal mucosa have been found to be acceptable for laryngeal grafting.8

As this type of operative undertaking is a "plastic" procedure, it cannot be emphasized too strongly that reconstruction must not be attempted in the face of obvious infection. Accurate reapproximation of the normal anatomic components coupled with selective resection of localized pathologic lesions is the keystone to reconstructive laryngeal surgery. Recently, it has been suggested that multistaged operations can be avoided by primary resection and reanastomosis when the cicatricial stenosis is subglottic in position and of limited area.9

Two cases of cicatricial larvngeal stenosis recently have been treated at the J. Hillis Miller Health Center. These cases are the basis of this report.

Report of Cases

Case 1.—A 13 year old boy, injured in an automobile accident on June 10, 1962, was hospitalized immediately. On admission, subcutaneous emphysema of the neck and laryngeal stridor were noted. The larynx was painful. He was treated with bed rest and antibiotics for 10 days and then released. At the time of discharge, he was totally asymptomatic. Two weeks following discharge, breathing became more difficult, and on July 19, a tracheostomy was performed after laryngoscopy showed cicatricial laryngeal stenosis.

In August, the patient was referred to the University of Florida Teaching Hospital. At the initial examination, it was noted that the thyroid cartilages were blunted anteriorly and deviated to the left. With the tracheostomy tube occluded, only a small amount of air could be moved through the larvnx.

On August 3, direct laryngoscopy was carried out under general anesthesia. Replacement of the left vocal cord and the anterior portion of the right vocal cord by scar tissue was observed, as well as a small posterior laryngeal lumen (ng. 1). The larynx was then surgically exposed. To the left of midline, there were fractures of the crycoid and thyroid cartilages anteriorly. Most of the left thyroid ala between midline and the fracture line had been destroyed. On opening the larynx, it was observed that the left ventricle was obliterated and that the

^{*}NIH Trainee and Resident in Otolaryngology, University of Florida College of Medicine, Gainesville. **Associate Professor of Surgery and Chief of Otolaryngol-ogy Division, University of Florida College of Medicine, ogy Divisio Gainesville.

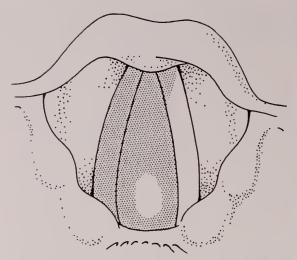


Fig. 1. — Direct laryngoscopic view of larynx in case 1. Stippled area indicates scar.

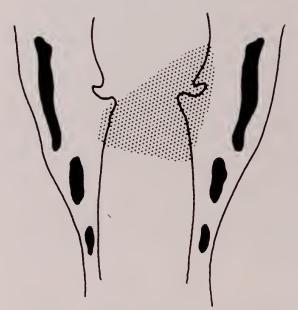


Fig. 2. - Section of larynx in case 1. Stippled area indicates scar.

area of stenosis extended subglotticly, especially anteriorly

(fig. 2).

The larynx was reconstructed in one stage by excising the scar tissue and grafting the raw surface with a split thickness skin graft obtained from the abdomen. The graft was held in place by a sponge rubber stent which was anchored in the larynx by through-and-through stainless steel sutures (fig. 3).

Twelve days after the first operation, the patient was returned to the operating room and the sponge rubber mold was removed through an operating laryngoscope. An acrylic obturator was inserted and was anchored in position by means of heavy silk strings which passed through the distal end of the obturator and which were brought out through the tracheostomy stoma below and then tied around his neck.

Between August and October, four endoscopic removals of granulation tissue near the tracheostomy stoma were required. It was thought that the constant to-and-fro motion of the silk strings was responsible for the excessive

granulation tissue formation. On November 10, therefore, the acrylic obturator was replaced by a soft plastic one with a distal flange long enough to be brought out through the tracheostomy opening (fig. 4).

On December 19, the laryngeal obturator was removed. The airway was adequate with the tracheostomy cannula closed. The voice was fair, and the patient could swallow without aspiration. He was referred to our speech therapist, and instruction in voice rehabilitation was begun. Remarkable progress and improvement in his voice have resulted in four months of intensive therapy. At the present time, he still has a small tracheostomy tube in place, but this remains corked continuously.

Case 2.—A 30 year old woman was momentarily knocked unconscious in an automobile accident on Aug. 4, 1962. After regaining consciousness, she appeared to be uninjured. She was hospitalized, however, for observation. Twelve hours after the accident, her neck began to swell, she felt warm, and her breathing became progressively more difficult. An emergency tracheostomy was performed. Following this procedure she noted a steady loss of ability to speak.

Laryngoscopy, two weeks after the original injury, confirmed the presence of laryngeal stenosis. Eighteen days after the accident, she was referred to the University of Florida Teaching Hospital. Direct laryngoscopy revealed normal vocal cords and complete subglottic stenosis (fig. 5).

At operation, it was discovered that the tracheostomy tube had been introduced through the crycothyroid membrane. A portion of the crycoid and thyroid cartilages was missing in the midline anteriorly. The subglottic scarring was extensive (fig. 6). The tracheostomy tube was removed and was repositioned at a lower level. The scar tissue was excised and the raw surface lined with a vaginal mucosa graft applied over a sponge rubber mold. Twelve days later, the sponge rubber mold was removed, and an acrylic obturator was inserted and anchored as in case 1. The patient tolerated the obturator well. No excessive granulation tissue was formed.

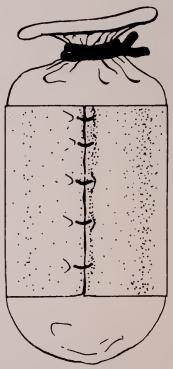


Fig. 3. - Skin graft applied over rubber stent (sponge rubber core covered by finger cot).



Fig. 4. — Method of securing soft plastic obturator by means of flange extending through tracheostomy stoma.

On January 4, 1963, the laryngeal obturator was removed. At that time, she had a reasonably good voice, could breathe with the tracheostomy tube covered, and could swallow without aspiration. The tracheostomy tube was left in place.

On January 18, on a follow-up examination, it was noted that the laryngeal airway was greatly diminished. On January 23, she was subjected to operation again. Anteriorly, at the level of the crycoid cartilage, there was a reaccumulation of scar tissue. This was excised and the raw surface covered with a buccal mucosa graft. At the present time, a soft plastic obturator is in place.

Discussion

Prevention of cicatricial laryngeal stenosis is, by all standards, the best treatment of this condition. This can be achieved only by early diagnosis. Open wounds of the neck and larynx pose no problem as attention is directed to the area by the very nature of the injury. Closed injuries of the larynx, on the other hand, are frequently overlooked as symptoms and signs are initially mild and misleading. The voice may be completely normal or only a bit husky. Respiration may be completely quiet, or there may be only minimal stridor. Cartilaginous injury may not be readily palpable. Subcutaneous emphysema of the neck may be totally absent early after injury. A good history of impact areas in accident victims will alert the physician to the possibility of larvngeal injury. Once the possibility of laryngeal injury is raised, the proper diagnosis will not be missed often.

It has been emphasized repeatedly in the literature that early diagnosis and treatment of laryn-

geal injuries will in a high percentage of cases restore the larynx to normal. Laryngeal mucosa tears, large hematomas, fractures, and cartilaginous dislocations lend themselves well to antibiotic coverage, internal stenting of the larynx, and temporary tracheostomy. If perichondritis and its destructive sequelae can be prevented, the obturator can be removed in four weeks, and one can be reasonably assured that the larynx so treated will be a normally functioning one.

Once cicatricial stenosis of the larynx is established, correction becomes a long drawn out and expensive proposition. The reconstructed larynx, though functional, will never be normal.

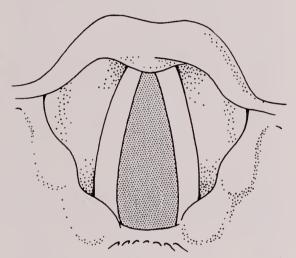


Fig. 5. — Direct laryngoscopic view of larynx in case 2. Stippled area indicates scar.

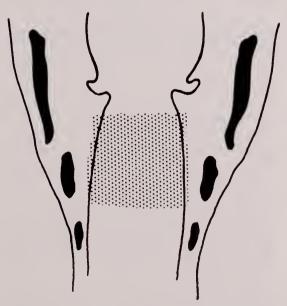


Fig. 6. — Section of larynx in case 2. Stippled area indicates scar.

Jackson and Jackson¹⁰ emphasized that if a larynx is to grow and mature properly, air must pass through it. At the present time, the patient in case 1 is breathing through his larynx, and it will admit a seven millimeter bronchoscope. It remains to be seen whether or not the larynx will enlarge at a normal rate and will provide an adequate airway as the patient matures.

From the surgeon's point of view, re-establishing an adequate airway and removal of the tracheostomy tube are the primary goals. From the patient's point of view, however, restoration of a functional voice is equally important. For this reason, the operator must take every precaution at the time of surgery to preserve the recurrent laryngeal nerves. It is equally important to insure that the patient will receive speech therapy after conclusion of the surgical procedures. The voice which remains after laryngeal reconstruction is usually quite abnormal, and most patients are disturbed and embarrassed by the various tonal qualities and their inability to control their "new" voice. It is in these areas that speech therapy plays such a vital role in rehabilitation. Not only does it improve the patient's vocal habits, but it also restores his self confidence and reduces his many anxieties.

Case 2 graphically illustrates the importance of leaving the laryngeal obturator indwelling for

a minimum of six months. In some cases, it may be necessary to leave it for longer periods of time, especially where there has been considerable loss of laryngeal cartilage.

Summary

Two cases of cicatricial laryngeal stenosis are presented. The need for prolonged laryngeal support by the indwelling obturator is emphasized. The importance of speech therapy in total rehabilitation is pointed out.

References

- Fitz-Hugh, G. S.; Wallenborn, W. M., and McGovern, F.: Injuries of the Laryux and Cervical Trauma, Ann. Otol., Rhin, & Laryug. 71:419-442 (June) 1962.
 Jackson, C.: High Tracheostomy and Other Errors as the Chief Cause of Chronic Laryugeal Stenosis, Surg., Gynec. & Obst. 32:392 (May) 1921.
 Holinger, P. H., and Johnston, K. C.: The Management of Chronic Laryugeal Stenosis, Ann. Otol., Rhin, & Laryug. 67:496-515 (June) 1958.
 Schmiegelow, E.: Stenosis of Laryux; New Method of Surgical Treatment, Arch. Otolaryug, 9:473-493 (May) 1929.
 Arbuckle, M. F.; Cause and Treatment of Cicatricial

- Arbuckle, M. F.: Cause and Treatment of Cicatricial Stenosis of Laryux, Ann. Otol., Rhin. & Laryug. 39:134-143 (Mar.) 1930.
 Figi, F. A.: Chronic Stenosis of Larynx with Special Consideration of Skin Grafting, Ann. Otol., Rhin. & Laryug. 49:394-409 (June) 1940.
 Jackson, C.: Stenosis of Larynx, with Special Reference to Curative Treatment With Core Moulds, Tr. Am. Laryng., Rhin. & Otol. Soc. 42:12-24, 1936.
 Harpman, J. A.: Management of Raw Areas in the Larynx, Arch. Otolaryng. 73:678-680 (June) 1961.
 Ogura, J. Il., and Roper, C. L.: Surgical Correction of Traumatic Stenosis of Larynx and Pharynx, Laryngoscope 72:468-480 (Apr.) 1962.
 Jackson, C., and Jackson, C. L.: Laryngeal Stenosis—Growth of Larynx as Factor in Treatment, Laryngoscope 42:887-889 (Nov.) 1932.

University of Florida.

Early Recognition of Cutaneous Malignant Melanoma in Adults

TOBIAS R. FUNT, M.D. FORT LAUDERDALE

Although the histologic diagnosis of cutaneous malignant melanoma has been greatly clarified,1.2 prompt clinical recognition of such a malignant tumor remains an enigma³ in the absence of notable growth, ulceration, adenopathy, satellite lesions, or pigmentation. 4.6

This report suggests that an early clinical sign of malignant transformation in a benign-appearing nevus may be represented by a faint, erythematous marginal halo seen more readily with the aid of magnification.

From the Department of Dermatology, University of Miami School of Medicine, Miami.

Analysis of Series

Serial sections of 140 pigmented nevi, excised from 125 adult patients, were prepared and examined histologically in this office and their clinical histories reviewed. One hundred and thirtyfive of these lesions, including lesions with junctional elements, were benign clinically and histologically. In this group, seven lesions were traumatized nevi, showing considerable inflammation.

Table 1 summarizes the remaining clinical data concerning five adult white patients with benignappearing nevi diagnosed histologically as cuta-

Table 1.—Malignant Melanomas With Marginal Inflammation

Pa- tient	Age Sex	Lesion	Size	Site	Duration	Course After Local Excision
	39 F	Brown Flat	Diameter 9.0 cm.	Right upper arm	Lifetime	1 yr., healed
	41 F	Brown Flat	1.1 cm.	Left forearm	12 yrs.	6 yrs., healed
	50 F 58 F	Black Flat	1.0 cm.	Right upper arm	6 mos.	6 yrs., healed
	58 F 60 M	Brown Raised Brown	0.5 cm.	Left lower leg	Lifetime	1 yr., healed
3	00 141	Raised	1.5 cm.	Left shoulder	8 mos.	6 yrs., healed

neous malignant melanoma by two pathologists. Basic criteria for the microscopic diagnosis of primary malignant melanoma included cellular pleomorphism and hyperchromasia associated with junctional nevus activity. These nevi were excised widely because each one possessed an inflammatory rim without history of injury to account for it. The lesions occurred on the extremities. Follow-up examinations, conducted for six years in three patients, failed to reveal evidence of recurrence. In two other patients, the lesions were healed one year after wide local excision of the nevi.

Comment

Judging by the high rate of mortality in the first five years after treatment of cutaneous melanoma, 7-10 the diagnosis of this disorder is often made too late in the course of the disease to save the patient's life.

In this study, observations of nevi were made in an effort to find and identify a clinical change in a nevus that may be detected before other presently known criteria for the diagnosis of cutaneous melanocarcinoma. Inflammatory nevi in adults became the object of study. Three observations motivated this investigation. Firstly, dermatopathologists observe many nevi with junctional activity in children. When such changes are related to age, it appears that the nevus cells drop off and become more intradermal¹¹ in older patients. It is not uncommon to find such nevi in children exhibiting perimarginal redness, thus suggesting that the marginal changes may be the first observable changes indicative of junctional activity. In adults, junctional activity in benign nevi is as unusual as is inflammation and raises the question, when they occur, of a possible relationship and a warning that the nevus is undergoing changes in the direction of melanocarcinoma. Secondly, this study of inflammatory nevi was spurred on by histologic studies in this office of the cytodiagnosis of benign nevi as compared to melanocarcinomas. In reviewing the cellular morphology of these lesions, it is noted that untraumatized benign nevi in adults do not exhibit inflammatory cellular changes whereas inflammation is a constant and progressive feature of malignant melanomas. Thirdly, redness about some melanomas has been previously described as a clinical characteristic.¹²

Marginal inflammation, like ulceration and hyperpigmentation, should not be considered pathognomonic of melanocarcinoma for such changes are seen in other lesions, too. These clinical characteristics, however, when observed in a nevus, suggest malignancy and warrant careful consideration.

Traumatized benign nevi may exhibit areolae of redness, but usually a history of recent injury is obtained. Seborrheic keratoses, angiomas, and pigmented basal cell epitheliomas may be inflamed at their margins, but they possess distinguishing characteristics to exclude them from consideration as nevi.

Summary and Conclusions

Untraumatized benign nevi in adults do not exhibit inflammation clinically or histologically. The pink halo of inflammation noted clinically as a marginal change in unmolested nevi in this report may be an early sign of cutaneous malignant melanoma. Five patients, in whom this change was observed clinically, also had malignant melanoma histologically. The findings in these cases appear to justify continued awareness by the physician that even traces of inflammation about a mole in an adult should be respected as a warning sign of a possible malignant growth.

Traumatized nevi, seborrheic keratoses, angiomas, and basal cell epitheliomas may show erythematous changes peripherally, but are readily identifiable.

In the studies of this report, survival of three adult patients for six years may be indicative that the sooner the nevus with a red rim is detected and properly excised, the more likely a cure may result.

References

- Allen, A. C., and Spitz, S.: Malignant Melanoma: Clinicopathologic Analysis of Criteria for Diagnosis and Prognosis, Cancer 6:1-45 (Jan.) 1953.
 Allen, A. C.: Juvenile Melanomas of Children and Adults

- nosis, Cancer 6:1-45 (Jan.) 1953.

 2. Allen, A. C.: Juvenile Melanomas of Children and Adults and Melanocarcinoma of Children, A.M.A. Arch. Dermat. 82:325-335 (Sept.) 1960.

 3. McMullan, F. H., and Huberner, L. F.: Malignant Melanoma, Statistical Review of Clinical and Histologic Diagnoses, A.M.A. Arch. Dermat. 74:618-619 (Dec.) 1956.

 4. Sulzberger, M. B.: Kopf, A. W., and Witten, V. H.: Pigmented Nevi, Benign Juvenile Melanoma and Circumscribed Precancerous Melanosis, Postgrad. Med. 26:617-631 (Nov.) 1959.
- (Nov.) 1959.
 Becker, S. W.: Pitfalls in the Diagnosis and Treatment of Melanoma, A.M.A. Arch. Dermat. 69:11-30 (Jan.) 1954.

- Tompkins, V. N.: Cutaneous Melanoma: Ulceration as Prognostic Sign, Cancer 6:1215-1218 (Nov.) 1953. Buchanan, R. N. Jr.; Clinical Study of Malignant Melanoma. A.M.A. Arch. Dermat. 83:447-458 (Mar.) 1961. Daland, E. M.: Malignant Melanoma: Personal Experience with 170 Cases, New England J. Med. 260:453-460 (Mar.) 1050
- Stehlin,
- Stehlin, J. S. Jr.; Clark, R. L. Jr., and White, E. C.: Malignant Melanoma: Problems in Clinical Management, Am. Surg, 25:595-603 (Aug.) 1959.
 Pack, G. T.: End Results in the Treatment of Malignant Melanoma, A Later Report, Surgery 46:447-460 (Aug.) 1950
- Brandt, G.: Melanoma of Skin With Special Reference to Histologic Differential Diagnosis, Clinical Picture, and End Results of Treatment, Ann. chir et gynace. For and End
- 128, 1956.
 Bohnstedt, R. M.: Diagnosis and Differential Diagnosis of Malignant Melanomas, Strahlentherapie 107:354-370 (Nov.)

1601 East Broward Boulevard.

Vaginal Hysterectomy After Previous Surgery

HOWARD C. DUCKETT, M.D. AND J. B. WILLIAMS JR., M.D. JACKSONVILLE

The indications for vaginal hysterectomy have today been considerably broadened. The relative safety of this operation and its obvious advantages have made it the procedure of choice when a hysterectomy is indicated for benign diseases of the uterus.1-4 Nevertheless, previous pelvic surgery is frequently regarded as a contraindication to vaginal hysterectomy. Because we do not adhere to this concept, we reviewed our experience with this procedure and present a series of cases in one third of which previous abdominal pelvic surgery had been performed.

Analysis of Cases

During the period from January 1954 to January 1962, we performed a total of 221 vaginal hysterectomies on private patients admitted to the gynecologic service of Riverside Hospital. Seventy-three of these patients, or 33 per cent, had previously been subjected to 128 gynecologic procedures, listed in table 1. Sixteen patients had undergone two and four had undergone three separate pelvic operations. In this group 33, or 45.2 per cent, had had inadequate operations for sterilization. The indications for vaginal hysterectomy are specified in table 2, and the types of operation performed are shown in table 3.

At operation, no unusual problems were encountered, and the procedure was no more difficult because of the previous surgery. Adhesions involving the uterus, adnexa, and intestines presented no problem in separation. Inadvertently, in four instances the bladder was injured during separation from the uterus, but was repaired without difficulty with primary healing promptly ensuing. No blood transfusions were given during the operation, and only three postoperatively. All patients tolerated the procedure well.

Postoperatively, urinary retention, cystitis and other morbidity were well within the usual limits expected after vaginal hysterectomy. In 15 patients, or 20.5 per cent, infected hematomas of the vaginal cuff developed, but drained spontaneously or were drained by gentle probing of the vaginal cuff. The shortest period of hospitalization was five days and the longest period was 13 days. Eighty per cent of the patients were discharged by the tenth postoperative day.

Discussion

Hysterectomy is performed abdominally or vaginally, and there should be no competition between the two procedures. The method should depend upon the indications and the skill of the surgeon. Its relative safety and less discomfort.

From the Department of Obstetrics and Gynecology, Riverside Hospital, Jacksonville.

early ambulation and less serious complications are advantages of vaginal hysterectomy, and patients prefer this approach. The problem of hematoma of the vaginal cuff, however, is a disadvantage not associated with abdominal hysterectomy.

It is noteworthy that 33, or nearly half, of the 73 patients in this series previously subjected to surgical therapy had undergone inadequate operations for sterilization. In the hands of a competent gynecologist, the performance of a hysterectomy rather than a tubal interruption should present little additional hazard. Except for the childbearing function, the uterus is a dispensable organ. A woman can enjoy good health without it and also is free of certain inconveniences and dangers. In our opinion, when childbearing is no longer a consideration, hysterectomy is to be preferred to tubal interruption, fundectomy, uterine suspension, and other less definitive procedures.

Vaginal hysterectomy following previous abdominal pelvic surgery, in our experience, is not difficult, the operating time is not prolonged, and exposure is adequate for removal of the adnexal organs when indicated. In our series, there were no failures; no patient had to be subjected to laparotomy in order to complete the operation. No deaths or serious complications occurred, and hospitalization was not prolonged. On the basis of the data presented, we do not consider previous pelvic surgery a contraindication to vaginal hysterectomy. Choice of the vaginal route depends on the nature of the postoperative residual, not on the type of the previous operation. If the uterus is moderately mobile and there is some relaxation of the vaginal supporting structures, vaginal hysterectomy is to be preferred for the removal of the uterus in the treatment of benign disease.

Summary

An evaluation of vaginal hysterectomy as the procedure of choice following previous abdominal pelvic surgery is presented. Analysis of a series of cases representing our experience with this surgical measure provides the basis for our conclusion that vaginal hysterectomy is not contraindicated under such circumstances.

Table 1. - Previous Pelvic Operations

Uterine suspension	30
Unilateral salpingo-oophorectomy	20
Tubal ligation	14
Tubal resection	12
Ovarian cystectomy	12
Cesarean section	11
Anterior and posterior colporrhaphy	9
Bilateral salpingo-oophorectomy	5
Unilateral salpingectomy	3
Myomectomy	3
Amputation of cervix	2
Ventral fixation	2
Manchester operation	2
Fundectomy	2
Colpotomy for abscess	1
Total	128

Table 2. - Indications for Vaginal Hysterectomy

Uterine prolapse and pelvic relaxation	24
Refractory bleeding	14
Symptomatic fibroids	14
Carcinoma in situ	11
Uterine prolapse	7
Dysmenorrhea	2
Sterilization (psychiatric)	1
	_
Total	73

Table 3. - Operations Performed

Vaginal hysterectomy and anteroposterior repair	38
Vaginal hysterectomy	29
Vaginal hysterectomy and unilateral	
salpingo-oophorectomy	5
Vaginal hysterectomy and bilateral	
salpingo-oophorectomy	1
	_
Total	73

References

- Bradford, W. Z.; Bradford, W. B.; Woltz, J. H. E., and Braun, C. W.: Experiences With Vaginal Hysterectomy, Am. J. Obst. & Gynec, 68:540-548 (Aug.) 1954. Ingram, J. M.; Withers, R. W., and Wright, H. L.: Vaginal Hysterectomy After Previous Pelvic Surgery, Am. J. Obst. & Gynec, 74:1181-1186 (Dec.) 1957. Jacobs, W. M.; Adels, M. J., and Rogers, S. F.; Vaginal Hysterectomy After Previous Pelvic Surgery, Obst. & Gynec, 12:572-574 (Nov.) 1958. Jacobs, W. M.; Rogers, S. F.; Scheihing, W. C., and Adels, M. J.; Advisability of Vaginal Hysterectomy After Previous Pelvic Operations, J. Int. Coll. Surg. 34:196-199 (Aug.) 1960.

2033 Riverside Avenue.

Diabetes as a Health Problem in Florida

JAMES E. FULGHUM, M.D. JACKSONVILLE

The control of infectious disease has saved many lives and has been responsible, in large measure, for the population living longer and reaching the age in life when the chronic diseases become more commonplace. As people live longer, the diabetic population in the state is expected to undergo significant increases, even much more rapid than the general population increase. Dr. Hugh L. C. Wilkerson estimated that by 1985 there will be a 75 per cent increase in the number of diabetics as compared to a 22 per cent increase in the general population of the United States.¹ It is noted from the latest United States Census data for Florida that those persons 45 years of age and older accounted for 31 per cent of the state's population.

In 1962 the estimated number of deaths in Florida due to diabetes was 751, and the death rate based on 10 months' experience was 14.0 per 100,000 population. A recent study² has been made of the Florida death certificates in which diabetes was listed as the primary or the secondary cause of death. From 1952 through 1961, 5,485 Florida residents died as a result of diabetes. Females of both races accounted for 56 per cent of these deaths. In 1961 this disease was responsible for 1.6 per cent of the total fatalities and ranked as the eighth cause of death in the state.

The distribution of deaths, due to diabetes mellitus among Florida residents, as to race and sex during the 10 year study is of interest and is shown in table 1. Nearly 92 per cent of the 5,485 deaths due to this disease occurred in groups 45 years of age and older.

The death rates for the nonwhite female were higher than those for any other group, reaching the peak of the curve at 153.3 per 100,000 in ages from 55 to 64 in contrast to those for the white female who showed the highest rate of 127.4 in the 75 plus age group.

A comparison of the death rate from diabetes per 100,000 population among the various age groups by race and sex can be seen in figure 1.2 In the early age groups there was little difference between the rates racially. The first marked increase took place with a sharp rise in the rates

for the nonwhite race between the ages of 25 to 34 and 35 to 44. This rise was primarily due to the increase in deaths among the nonwhite females, and the increase in this group continued until it reached its peak in the 55 to 64 year age group. A similar 10 year study³ of the diabetes rates in Georgia showed a marked rise in the death rates for the nonwhite female between the ages of 35 and 54.

Additional study of the nonwhite diabetic female group is indicated to determine why the nonwhite female dies 20 years ahead of her white counterpart and also 20 years ahead of the nonwhite male (fig. 1). Screening for diabetes is oftentimes undertaken in the older age groups, that is, those over 40 years of age. Our data indicate that earlier screening for diabetes in the nonwhite female group should be instituted, probably no later than at the age of 25 years. Antepartum care for this group should include careful urine examination for albumin and routine blood sugar examination made two hours after a measured carbohydrate meal.

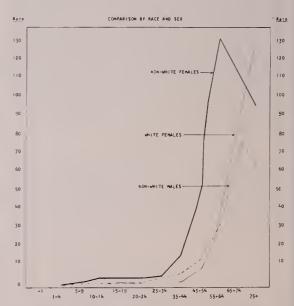


Fig. 1.—Average death rate per 100,000 population according to age group, due to diabetes mellitus, by race, Florida 1952-1961

Study of 5,485 cases by age group

Bureau of Vital Statistics Florida State Board of Health

Director, Chronic Diseases Division, Florida State Board of Health.

FULGHUM: DIABETES AS A HEALTH PROBLEM

Table 1. — Death Rates Per 100,000 Population for Diabetes Mellitus by Age Groups, Race and Sex

Florida, 1952-1961

Race and Sex						Age Gre	oups						
	-1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75+	
	0.1	0.2	0.2	0.7	1.0	1.1	2.1	4.3	12.6	32.6	62.3	116.9	
Males	0.0	0.3	0.1	0.5	0.7	1.1	2.5	4.4	10.0	28.7	57.8	108.4	
Females	0.2	0.2	0.3	0.9	1.4	1.2	1.2	4.2	15.1	36.1	66.8	125.0	
White	0.2	0.2	0.2	0.5	0.8	0.9	1.8	2.3	7.9	23.5	58.8	120.9	
Males	0.0	0.2	0.1	0.5	0.6	0.9	2.2	3.1	8.2	24.0	56.2	113.8	
Females	0.3	0.2	0.3	0.6	1.1	1.0	1.4	1.5	7.6	23.1	61.4	127.4	
Nonwhite	0.0	0.4	0.3	1.3	1.8	1.9	3.4	13.8	35.9	96.4	94.0	75.7	
Males	0.0	0.2	0.1	0.4	0.5	0.9	3.6	5.3	9.2	30.0	72.0	54.9	
Females	0.0	0.2	0.5	1.7	2.4	2.0	3.2	16.8	53.3	133.6	114.2	96,6	
								Study of Bureau of Vital 5,485 cases Florida State Box					

The nonwhite female bearing large babies (over 10 pounds) must be regarded as prediabetic and handled accordingly. A strict weight reduction regimen must be prescribed if the woman is grossly overweight. Certainly if the patient is a relative of a diabetic, regular and careful blood sugar evaluations must be carried out.

Summary

A study of 5.485 diabetic deaths occurring in Florida between 1952 and 1961 is reported.

From the data presented, the nonwhite female dies from diabetes 20 years ahead of the white

female and the nonwhite male.

Screening the nonwhite female group for diabetes must begin no later than 25 years of age, and careful antepartum evaluation of this group must be undertaken. Further study is indicated of diabetic and prediabetic Negro women.

References

- Wilkerson, Hugh L. C.: Motion picture, "Diabetes and Its Long Range Control."
 From the Bureau of Vital Statistics, Florida State Board of Health.
 Unpublished data, Charles T. Brown, M.D., Georgia State Health Department.

Box 210.

Would You Like to Participate in Scientific Program Florida Medical Association's Annual Meeting?

For the Scientific Program of the Ninetieth Annual Meeting of the Florida Medical Association, the Committee on Scientific Work contemplates multiple symposia upon:

- 1. Pvelonephritis
- 2. Genetic and Developmental Aspects of Disease
- 3. Surgical Diseases of the Newborn
- 4. Functional Disorders of the Gastrointestinal Tract
- 5. Medical Economics
- 6. Adaptation of Man to Unusual Environmental Conditions

Participants should be members of the Association with a special interest in (numbers correspond to above topics): 1. Urology, Pediatrics, Pathology, Radiology; 2. Obstetrics-Gynecology, Pediatrics, Radiology, Orthopedics; 3. Radiology, Pediatrics, Anesthesiology; 4. Surgery, Gastroenterology, Psychiatry, General Practice; 5. General Surgery, Internal Medicine, Public Health; 6. Otology, Psychiatry, Obstetrics-Gynecology.

Abstracts of not more than 50 words should be received by the Committee on Scientific Work, P. O. Box 2411, Jacksonville, no later than December 10.

Richard C. Dever, M.D., Chairman Committee on Scientific Work

Indications for Neck Dissection

Upon completion of medical school and even internship, an individual is at least vaguely aware that some primary head and neck tumors are better treated by surgery, that others are better treated by radiation therapy, and that in a third group both modalities, if skillfully applied, offer almost identical prognoses. This same individual has learned that the site of the neoplasm, its histological type, its size and the presence or absence of metastases, regional or distant, determine the proper modality or modalities of therapy.

The trainee, having now progressed on the road to specialization, may attend Tumor Conference after Tumor Conference and, perhaps understandably, believe that indications for neck dissection depend on the phase of the moon at that particular time or the forcefulness, or lack thereof, of a member of the Conference.

This unfortunate individual, who by this time may be well along the way in his postgraduate specialty training, received help when Dr. Hayes Martin, on the basis of accumulated evidence, offered certain general indications for neck dissection some years ago. His criteria offer a principle from which to deviate when necessary. It is these criteria that have formed the basis for decisions on the Head and Neck Service at this institution and have served the Service well.

Since there always are those who make a fetish of semantics, neck dissection, prophylactic neck dissection, radical neck dissection and other like terms are to be understood in the meaning set forth by Martin. Neck dissection, the term in question, then means the removal of the lymphatic vessels and lymph nodes of an area of the neck bounded superficially by the platysma muscle, anteriorly by the midline, posteriorly by the anterior border of the trapezius, cephalad by the mandible, caudid by the clavicle and deeply by the deep fascia. Structures removed to enhance the efficacy of lymphatic excision include the internal jugular vein, the sternocleidomastoid and omohyoid muscles, the spinal accessory nerve and branches of the cervical plexus with the submaxillary gland.

With this preamble, what are the indications for neck dissection? It is convenient to consider first some categorical contraindications. Excluded are those patients who obviously would not

be helped by the procedure: the individual who has distant metastases, the patient who has a second disease that is likely to be fatal long before he is troubled by metastases present in the neck, and the like. Also excluded are the rare individuals who, because of medical considerations, will not tolerate this radical but nevertheless benign "surface surgery."

Neck dissection, then, is indicated in those individuals who have histologically proved or clinically diagnosed cervical lymph node metastases if the primary tumor is controlled or controllable. A second indication occurs in the situation where the neck is entered by the surgeon in the process of surgically controlling the primary tumor. In such instances the upper part of the dissection has often been done while controlling the primary lesion and it is expedient to complete the anatomical dissection. Of perhaps more importance is the fact that metastases may not be readily recognized in a neck previously distorted by cicatrix. Finally, if metastases eventually do develop and are recognized, the previous distortion of tissue planes makes the procedure more difficult and less an anatomical block dissection of the regional lymphatic vessels and nodes.

To those initiated in the type of surgery under discussion the thus far glaring lack of discussion of prophylactic or elective neck dissection is untenable. These adjectives connote neck dissection in the absence of demonstrable metastases and in situations where the neck is not entered while controlling the primary lesion. The members of the Head and Neck Service at this institution are aware of the urgings and arguments for elective neck dissection that appear in various journals from time to time. Until, however, it is demonstrated that end results are significantly improved by performing the procedure prophylactically, it is anticipated that the obvious alternative will continue to be employed. This alternative demands observation of the patient and neck dissection only if and when metastases appear.

 Martin, H.; Del Valle, B.; Ehrlich, H., and Cahan, W. G.: Neck Dissection, Cancer 4:441-499 (May) 1951.
 JOHN J. FOMON, M.D., PROFESSOR OF SURGERY UNIVERSITY OF MIAMI SCHOOL OF MEDICINE MIAMI

President's Page

Utilization of the Blues

Recently, it was my privilege to attend the annual informational meeting of the Board of Directors and the Managing Executives of Blue Cross-Blue Shield of Florida, Inc. This is an experience which should be shared with all the active, participating members in the state.

Let's get the proper background with a few authentic facts and figures. On June 1, 1963 Florida Blue Shield had a total enrollment of more than 907,000 members, and Blue Cross a membership of almost a million. The sad story is that about 30 million dollars was paid by Blue Cross in 1962 for claims, representing a utilization incidence for inpatient admissions of 175 per thousand members. This trend has been upward during the past few years: from 140 per thousand in 1950 to 184 per thousand by the end of March 1963. That means an increase of 31.4 per cent in the number of subscribers going to the hospital during the past 12 years. Analysis of the hospital length of stay over the same period shows an increase. Simultaneously, the total cost of hospital care has been greater. Now the average cost per case for paid claims is close to \$250, with an average daily cost of \$36.50. Of this amount, Blue Cross in Florida has paid about 79 per cent. The only source of funds for payment of these huge sums is the premiums obtained from subscribers. So, naturally, rates have gone up. Various factors have contributed to this increase; and there is no simple answer to all of the problems.

We take great pride in the magnificent record of low cost service amassed by our own Florida organization of Blue Cross-Blue Shield, headed by Mr. H. A. Schroder and his very competent staff. Last year, because of good management, they paid out a record high of 94 cents from every dollar received. And they reduced the percentage of income used for operating expense by 8.6 per cent. This is a fine return

for the money paid by subscribers.

Voluntary health insurance is important to private enterprise, especially to Medicine. Coincident with recent, rapid expansion the variety and flexibility of Plans have been greatly improved. But there is a constant need to study our contracts and to devise new approaches and fresh ideas commensurate with present demands. Additional concepts in rating methods have become necessary. Many modifications have been applied in Florida, to keep step with our rapidly increasing population, and with the related problems in industry. Group coverage for national employers in this area has posed difficulties because of regional variations in benefits and services. Florida Blue Cross-Blue Shield finds it difficult to compete on an even basis with commercial

carriers, which have a unified national approach.

Although rates have gone up, we should not blame Blue Cross for the increased costs of hospitalization. Premiums are based upon hospital charges for the contract benefits allowable to subscriber members of the Plan. It is hoped that in December (1963) the A. M. A. Commission to Study the Costs of Hospital Care will, after a study of three years, come up with some proposals of changes and methods for control of hospital costs. It is a complex problem. But some action seems necessary since cost-per-day and cost-per-stay are exceeding the cost-of-living index in recent years. We suggest that you read the report prepared by the Florida Commission on the Cost of Medical Care, entitled: "Is There Any Unnecessary Utilization of Hospital Facilities in Florida?" (May 1963). This commission, which is representative of organized medicine, the insurance industry, and hospital management, recommends the establishment of utilization committees at the local level in order to obtain more efficient and effective usage of hospital facilities.

J. Florida M.A./October, 1963

The Blue Shield management has been aggressive in the promotion of new business and in selling our present programs, which are designed for the services and benefits that people are able and willing to buy. But, often, it has not received enthusiastic support from some members of the medical profession. This lack of interest may be due, in part, to a need for awareness by the members of the Florida Medical Association.

What can we do to help in the solution of these problems? Blue Cross, Hospital Administration, Blue Shield, and the participating Physician have definite responsibilities in the control of rising health care expense. Unnecessary or unduly prolonged hospitalization means higher premium rates. Inefficient management or obsolete methods of procedure in the hospital will do the same thing. Educational campaigns should help employers acquaint their employees with the personal advantages of using their benefits and protection judiciously. The Committee on Physician Relations, under the chairmanship of Dr. John D. Milton and with the know-how of W. J. Stansell for Blue Shield, is planning continued education of old and new physician members concerning Blue Cross and Blue Shield coverage. It will conduct informational meetings at county medical societies, make contacts with senior medical students and newcomers in the medical profession of the state, and offer its help in the formation of utilization committees in the community hospitals. Your Board of Governors has recommended the establishment and implementation of Voluntary Health Insurance Review Committees in each component county medical society to serve locally as liaison with the state claims committee.

Excessive utilization of hospital services and Blue Cross benefits does not often involve deliberate deception or collusion. But the problem is more subtle. Injudicious or unwise usage may jeopardize the whole Plan, which is so important to continued freedom in Medicine and private enterprise. The people have proved that they want voluntary health plans. A teamwork approach should accomplish a reduction in the costs of hospitalization, which are a primary reason for increased health care expense. Members and subscribers should, in the phraseology of the prescription writer, use their Blue Cross-Blue Shield benefits only "P.R.N.", if abuses are to be controlled.

We have an individual responsibility.

Women wopinelian



Surgical Treatment of Parkinsonism and Other Hyperkinetic Disorders

The past decade has witnessed the discovery and elaboration of significant new knowledge and techniques in the fields of neurophysiology and the neurosurgical treatment of extrapyramidal movement disorders. The efficiency of application and the precision in use of the Fairman stereotactic apparatus certainly rank as a noteworthy contribution to the surgical treatment of these problems. This technique undoubtedly is less time-consuming and significantly more precise than earlier methods employing bony landmarks of the skull as reference points or earlier methods which sometimes produced a variable degree of tissue destruction.

In view of the remarkable results reported in the paper by Drs. Perlmutter and Fairman on the surgical treatment of hyperkinetic disorders, published in this issue of The Journal, it would be of additional interest if the authors clearly indicated which reference points they utilize in making their electrode placement. In comparing their reported results with those reported by others, it would be pertinent to know whether they employ the same reference points or whether they rely entirely on physiological verification, which, as they indicate, is not entirely a reliable sign because of the variability of response. It would be reassuring to know that a negative physiological response, with respect to pyramidal function, generally is sought, since this is helpful in a negative way in that it helps to provide some assurance that the electrode has not been incorrectly placed within or too close to the pyramidal projection pathways, thus providing assurance that precaution has been taken to attempt to avoid the complication of hemiplegia.

Under the discussion of their results the authors have reported "satisfactory results" in 90 per cent of their patients. This figure is a little higher than that reported by most other surgeons in the past. The crux of the problem in interpreting such results is the definition of the term "satisfactory." Unfortunately, the criteria of im-

provement are not always defined in sufficient detail to allow one to compare the results of one surgeon with the results of another. For example, I recall one patient whom I carefully examined both before and after an operation performed for disabling rigidity, and my assessment of the degree of improvement was quite different from the assessment of the surgeon, although there was no doubt that the patient had achieved a good result and had benefited by the operation.

Another difficulty in the evaluation of the results of surgery for the hyperkinetic disorders has been the assumption by some that "satisfactory results," as reported by the surgeon, means the same as satisfactory improvement in the patient's clinical status. There is no doubt that truly remarkable results have been achieved with respect to certain specific findings, such as rigidity and tremor. Unfortunately, even the virtually complete relief of tremor and rigidity does not always necessarily mean really satisfactory improvement in the over-all clinical status of certain patients. For example, I recall one patient whom I examined in detail and could confirm the fact that the patient had achieved remarkable and nearly complete relief of tremor and rigidity, apparently as a result of the operation, which had been performed by a prominent neurosurgeon in Boston. Nevertheless, I might add parenthetically that the patient remained virtually incapacitated by akinesia and vegetative symptoms, which are apt to be the least responsive to surgery and the least talked about, but sometimes the most incapacitating part of the patient's clinical problem.

The several case reports of Drs. Perlmutter and Fairman are very well written up to describe the truly remarkable benefits which may sometimes be achieved from chemopallidectomy, and the authors may point with justifiable pride to the potentialities of their handiwork. The impact of the prospective good results obtainable by surgery should, however, be tempered by a realistic statement, or perhaps a case report, concerning

those features of certain cases of parkinsonism which cannot be expected to improve from surgery, even when carried out by the most capable of surgeons.

The authors do allude to the problem of potentially poor results in their comment at the end, concerning the care taken in patient selection. Papers dealing with the results of such surgery would be of greater benefit to physicians having responsibility for the management of patients before and after surgery if the authors plainly indicated which symptoms ordinarily could not be expected to improve from surgery, as well as those

which ordinarily can be expected to improve, that is, a working set of criteria for case selection.

We are fortunate in having capable neurosurgeons who undoubtedly have something worth while to offer the profession in Florida. It is to be hoped that it will be possible to formulate guide lines for case selection in the surgical treatment of hyperkinetic disorders, so that the treating physician can know what can as well as what cannot be expected from such treatment.

JOHN A. BROWARD, M.D. CORAL GABLES

Ethics and the Medical Profession

Of all the known professions, the medical profession has been looked upon since time immemorial as the noblest of them all. It is a profession which deals solely and exclusively with the human being, ministering to his pains and suffering, sharing in his joys and happiness, entering into his countless emotional and vicarious reactions to this wonderful biological concept called life. Thus, it is a profession of great personal contact and confidences which generate a relationship of trust and faith. The very nature of this intimate relationship imposes a responsibility on each physician which cannot and ought not to be taken lightly. The duties and responsibilities of the physician toward his fellow man must be exercised with meticulous care and superior judgment so that medicine's traditionally high standards of professional integrity and ethics may be maintained.

In a spirit of self discipline and in a sincere effort to keep these standards high, each medical society has set up committees on ethics, sometimes termed a Board of Censors, sometimes a Grievance Committee, clothed with authority to investigate breaches of ethics of whatever nature and to mete out just punishment to offenders and violators. Whether these committees have fulfilled their lofty purposes is a matter of question and of even greater concern. Speaking flatteringly of these committees, a spokesman for the American Medical Association Department of Medical Ethics stated in an article in the AMA News in May 1962 that local medical societies help main-

tain medicine's high level of professional integrity through these committees on ethical practices.

While the statement seems fair enough and bears some semblance of the truth from a factual point of view, it leaves something to be explained. For one thing, it presumes that medicine's level of professional integrity is really that high; for another, it presumes that committees on ethical practices have helped to keep the level that high. Unfortunately, neither of these premises can be presumed. The timidity and lack of aggressiveness of some of these committees in handling complaints involving ethics would tend to rebut these presumptions. All too often, violations go unpunished, to the detriment of the entire profession, because a board or committee judging an alleged violation is timid or uncertain about its own interpretation of the standards of ethics.

Perhaps the difficulty stems from uncertainty of the meaning of the word "ethics." It is an elusive term and defies strict definition. Ethics is an abstract concept of philosophy dealing with morals, and attempting to set up standards of conduct and behavior under such vague ideals as right and wrong, good and bad, moral and immoral. Under the circumstances, it is conceivable that interpretations of the alleged breach of ethics may vary, and it is small wonder that a committee of doctors, judging a charge involving conduct and behavior, finds difficulty in agreeing upon a verdict except where the act complained of is so flagrant as to defy differences of interpretation.

One, then, is left to one's own conscience re-

garding the meaning of the term. Yet, despite its evasiveness, despite the apparent difficulty of exact definition, there is hardly a single responsible person who does not fully comprehend the meaning of the term "ethics." Like the English common law which forms the rockbed of American jurisprudence, it requires no definition, no interpretation, no elaboration. Custom, tradition, usage, mores have made its meaning clear in the minds of responsible persons. The fact that the word "medical" is coupled with the word "ethics" in no way dilutes the concept; it merely delineates the species to whom it is applied, in this instance the physician.

Thus, like the chain and its weakest link, the effectiveness of any committee on ethical practices is no stronger than the consciences and high moral standards of each of its individual members. Medicine, today, can ill afford to temper with those who would bring discredit upon it, and ethics committees must take a firmer and more resolute stand against offenders. Each physician bears a responsibility of good conduct and high ideals, and these must be fulfilled if the profession is to recapture some of the preeminence and lofty position it once held in the eyes of the public.

Franklin J. Evans, M.D., President Florida Academy of General Practice

To Refill or Not to Refill

The complexity and potentiality for both good and harm inherent in today's modern therapeutic agents demand that proper control over the use of drugs be exercised. Years ago when the therapeutic agents played a much lesser role in patient treatment, the matter of refilling prescriptions developed into a relatively regular pattern. Today, however, a much greater degree of responsibility must reside with both the physician and the pharmacist in order that the patient's best interest is served. The unlimited dosing with medication by the patient can produce irreparable harm. And long term toxicity with many of our newer medications is not uncommon.

In addition to the professional responsibility which is involved with the refilling of prescriptions, there is a legal requirement which is imposed upon the pharmacist. The Federal Food, Drug and Cosmetic Act specifically states that a drug bearing the legend "Caution—Federal Law Prohibits Dispensing without Prescription" cannot be dispensed unless with the specific authorization of the physician. Since the original medication prescribed by the physician reflects the result of his diagnosis and considered opinion as to the patient's needs, it follows that he should be knowledgeable with respect to the amount and length of time that such medication is to be uti-

Editor's note: This article was written at the request of Jesse W. Castleberry, M.D., of Orlando, Chairman of the Committee on Pharmacy of the Florida Medical Association. The House of Delegates at the May meeting in Hollywood approved the Committee's recommendation that an appropriate officer or member of the Florida State Pharmaceutical Association be requested to submit an article on the subject of problems between the physician and the pharmacist concerning prescription writing and filling. We are pleased to have this opportunity to present Mr. Rogers' views on this important subject.

lized by the patient. The drugs covered by such legal requirement include almost all of those commonly prescribed from digitoxin to Phenurone, including the antibiotics, the thiazides and all of the newer therapeutic agents.

Thus, it is obvious that a burden is placed on both physician and pharmacist to see to it that the patient's legitimate medication requirements are met with minimum inconvenience to all concerned and a proper appreciation and respect for the physician's treatment engendered in the mind of the patient. There are two common ways in which renewals of prescriptions can be handled. The first of these is by the physician specifically indicating on his original prescription, his refill instructions. These include the authorization of a fixed number of renewals or an indication that no renewals of the prescription should be made by the pharmacist. Such instructions will insure that the physician's desires are followed and the patient will receive the medication without interruption. Should the physician fail to make any notation, the pharmacist is placed in a difficult position when faced with the patient who seeks to have a prescription renewed.

In this case, the pharmacist must resort to the second alternative and call the physician for his oral authorization to renew the prescription. Many physicians have become somewhat disturbed by the increasing number of telephone calls that they are receiving from pharmacists and on occasion have even refused to acknowledge or return such calls. This is a practice which is most reprehen-

sible. This is not a procedure which the pharmacist relishes, but the patient's best interest and the law require that the physician be completely informed as to the medication being taken by his patients.

In addition, there is the problem of professional liability. Court cases have been decided in favor of patients when the proper care and procedures were not followed by physician or pharmacist. The failure of the physician to specify renewal instructions can cause patient dissatisfaction and create a situation which will alienate persons from the health professions.

A practice has developed in some areas whereby physicians are limiting the hours when they will accept calls from pharmacists and unfortunately the patients are not aware of this and cannot understand why they are denied their medication when they request it. Such a procedure is a severe handicap in view of the fact that the patient's needs and requests frequently cannot be anticipated and scheduled into a time period which has been arbitrarily proclaimed acceptable to the prescriber. Resentment develops and the patients question whether the health professions are genuinely concerned about them. Frequently the physician, when confronted by the patient, can save a great deal of the patient's time by calling the pharmacist rather than waiting for the pharmacist to call him-which usually occurs at the most inopportune time.

The free practice of the health professions of this country will continue only through the conviction of the public that its best interests are being served by the methods employed. Medicine and Pharmacy working cooperatively as separate and distinct professions, yet through combined efforts and actions, can insure our system of medical care. Mutual respect, understanding and cooperation are necessary. By specifying renewal instructions on the prescription or by graciously accepting telephonic communications, the physician can avoid inconvenience to himself, his patient and the pharmacist and avoid placing the pharmacist in a compromising position. He can insure that the patient's medication needs are properly satisfied and the necessary safeguards are provided at the least possible cost. Better public and interprofessional understanding must ensue from such cooperative practice and better patient care must necessarily result.

> B. S. Rogers, President-Elect American College of Apothecaries Jacksonville



Know Your Board of Governors

Appearing here are pictures and brief biographical sketches of the two new members of the Board of Governors of the Florida Medical Association for 1963 and also pictures of those who were reappointed. Brief biographies of the members who served last year and are continuing their duties were published in the October 1962 issue of The Journal.—T.M.

Jack Quillian Cleveland, M.D., of Coral Gables, is this year's member at large on the Board of Governors by appointment of the President of the Association.



Dr. Cleveland was born in Elberton, Ga., in 1907 and received his academic and professional training in his native state. He was awarded the B.S. degree by Emory University, Atlanta, in 1927 and the M.D. degree in 1931. After completing an internship at Grady Memorial Hospital, Atlanta, he served a residency at Jackson Memorial Hospital, Miami, from 1932 to 1934. Since that time he has engaged in the private practice of internal medicine in Coral

Gabies. During World War II he served from 1942 to 1946 as a lieutenant colonel in the Army Air Corps with overseas duty as Wing Surgeon, India Wing, China-Burma-India Theatre. Dr. Cleveland served the Association as chairman of the Committee on Medical Education and Hospitals from 1950 to 1956. He is a former secretary, trustee and president of the Dade County Medical Association. He has served as Assistant Clinical Professor of Medicine at the University of Miami School of Medicine since its inception.

Reuben B. Chrisman Jr., M.D., of Coral Gables, is the A.M.A. delegate on the Board of Governors for 1963. Born in Hazel, Ky., in 1911, Dr. Chrisman received



the B.S. degree from Murray State College, Murray, Ky., in 1933 and the M.D. degree from the Univer-sity of Tennessee College of Medicine, Memphis, in 1938. After serving an internship and a two year residency in obstetrics and gynecology at John Gaston Hospital, Memphis, he served for four years in the Army Medical Corps during World War II, completing his military service in 1946 with the rank of colonel. He has engaged in the private

practice of obstetrics and gynecology in Miami and Coral Gables since 1946. Dr. Chrisman has served the Association as chairman of the Committee on Medical Economics, as a member of the Board of Governors for eight years and also as an A.M.A. delegate for eight years. His A.M.A. activities include membership on the Council on Medical Service since 1955, Council on Legislative Activities since 1953, Committee on Maternal and Child Care since 1953, and Committee on Military Medicine Affairs from 1953 to 1958. He has served the Dade County Medical Association as secretary and as chairman of the Public Relations Committee and of the Board of Censors. On the faculty of the University of Miami School of Medicine he serves as Clinical Associate Professor of Obstetrics and Gynecology.



Warren W. Quillian, M.D. Coral Gables



Samuel M. Day, M.D. Jacksonville



S. Carnes Harvard, M.D. Brooksville



Henry J. Babers Jr., M.D. Gainesville



H. Phillip Hampton, M.D. Eugene G. Peek Jr., M.D. Edward L. Cole Jr., M.D. Chas. J. Collins, M.D. Tampa



Ocala



St. Petersburg



Orlando



Floyd K. Hurt, M.D. Jacksonville



Robert E. Zellner, M.D. Orlando



Ralph S. Sappenfield, M.D. Miami



Leo M. Wachtel, M.D. Jacksonville

Know Your Council Chairmen

In order that the members of the Association may know those who are serving as chairmen of the various Councils. The Journal is pleased to present biographical sketches of the new ones and the pictures of those who were reappointed. Information on those who served last year may be found in the January, 1963, issue of The Journal.

T.M.

keland is now

Jere Wright Annis, M.D., of Lakeland, is now chairman of the Judicial Council. The son of a physician, Dr. Annis was born in Minneapolis, Minn., in 1909. He



received his academic training at Dartmouth College, Hanover, N. H., and at Cornell College, Mount Vernon, Iowa, where he was awarded the A.B. degree in 1930. He returned to Minneapolis to enter the University of Minnesota Medical School and in 1934 the M.D. degree was conferred upon him by that institution. After completing an internship at the Minneapolis General Hospital, he spent three years as a fellow in internal medicine at the

Mayo Clinic. He then entered the private practice of medicine in Lakeland. During World War II he served from 1941 to 1946 in the Army Medical Corps, completing his military service with the rank of lieutenant colonel. Thereafter, he resumed the practice of internal medicine in Lakeland. Dr. Annis is a past president of the Association, has served on the Board of Governors for a number of years and was public relations officer in 1960. He is a former chairman of the Committee on Scientific Work, has served on a number of other committees and is a former Associate Editor of The Journal. A past president of the Polk County Medical Association, he is also a former secretary and trustee of that society. In addition, he is a past president and former secretary of the Florida Heart Association and visiting instructor to the University of Miami School of Medicine.

Hugh Alfred Carithers, M.D., of Jacksonville, was this year named chairman of the Council on Medical Education and Hospitals. Born in Winder, Ga., in 1913,



Dr. Carithers received his academic and professional training at Emory University, Atlanta, where he was awarded the A.B. degree in 1933 and the M.D. degree in 1937. After completing a two year rotating internship at Germantown Dispensary and Hospital, Philadelphia, he served residencies in 1941 and 1942 at St. Christopher's Hospital for Children, Philadelphia, and Children's Medical Service, Bellevue Hospital, New York City. Since that time he has en-

gaged in the private practice of pediatrics in Jacksonville except for a period of military duty during World War II as a captain in the Army Medical Corps. Dr. Carithers served the Association as chairman of the Committee on Credentials in 1961 and chairman of the Committee

on Internships and Residencies in 1962. He has served the Duval County Medical Society as chairman of the Public Health Committee for several terms and is currently its president. He was state chairman of the Florida Chapter of the American Academy of Pediatrics for six years, is a past president of the Florida Pediatric Society, and since 1960 has been an official examiner of the American Board of Pediatrics. He is a former director of the Northeast Florida Heart Association and since 1949 has served on the Florida Children's Commission.

Charles Robert Sias, M.D., of Orlando, serves as chairman of the Council on Medical Services. Dr. Sias was born in Rochester, N. Y., in 1918, and received his



premedical and medical training at the University of Rochester, where he was awarded the M.D. degree in 1941. After completing a rotating internship at Charity Hospital of Louisiana, New Orleans, he spent six months in industrial practice in Birmingham, Ala. He then entered the Medical Corps of the Navy during World War II, serving from January 1943 to July 1947 and completing his tour of duty with the rank of lieu-Ltenant commander. Upon

his return from overseas service in the European Theatre of Operations, he served residencies at the U. S. Naval Hospital, San Francisco, in medicine, the U. S. Naval Hospital, St. Albans, L. I., New York, in orthopedics, and Orange Memorial Hospital, Orlando, in surgery, before entering the general practice of medicine in Orlando in 1948. In the Association Dr. Sias has been chairman of the Committee on Public Health since 1962. He is currently president and was formerly treasurer and chairman of the Public Health and Legislation Committee of the Orange County Medical Society. Also, he is a past president of the Orange County Academy of General Practice and the Florida Academy of General Practice.

Walter Clifton Payne Sr., M.D., of Pensacola, is the new chairman of the Council on Special Activities. A native of Alabama, Dr. Payne was born in Luverne in



1889. He received his premedical education at the University of Alabama, Tuscaloosa. For his medical training he attended Tulane University School of Medicine, New Orleans, where in 1912 the M.D. degree was conferred upon him. He then served a two year internship at Charity Hospital of Louisiana, New Orleans. Since 1914 he has practiced general surgery and engaged in some general work in Pensacola. During World War JI he served as a lieutenant

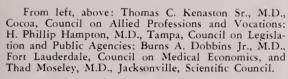
in the Medical Corps of the United States Navy. Dr. Payne is a past president and former member of the Board of Governors of the Association and has served in many other official capacities. He has served the Escambia County Medical Society as president, secretary-treasurer, chairman of the Board of Censors and chairman of various committees. Also, he is a past president of the Gulf Coast Clinical Society and of the Pensacola Tuberculosis Association and is serving as a member of the Hospital Advisory Council, Hill-Burton Funds for Florida. In 1953, the University of Florida conferred on Dr. Payne the honorary degree of Doctor of Science.











From left, right: Emmet F. Ferguson Jr., M.D., Jacksonville, Council on Specialty Medicine, and Mason Romaine III, M.D., Jacksonville, Council on Voluntary Health Agencies.









Cardiovascular Seminar

The Fifth Annual Cardiovascular Seminar of the Suncoast Heart Association and Hillsborough County Heart Association was held in St. Petersburg on January 26 and 27, 1963. There were 12 lectures and two luncheon panel discussions. The faculty was excellent, and the program was well presented. Many interesting points were brought out during the seminar.

Dr. Charles A. Hufnagel, Professor of Surgery, Georgetown University School of Medicine, Washington, D. C., said if a dissecting aneurysm of the aorta was not operated on, one third of the patients would die in the first 24 hours, one third would survive several days, and one third would survive weeks to years. He advocated the early surgical treatment of dissecting aneurysms. He also pointed out that a third of dissections arise distal to the arch, which is not a well known fact.

Dr. Henry I. Russek, Director of Cardiovascular Research and Consultant in Cardiovascular Disease, U. S. Public Health Service Hospital, Staten Island, New York, reviewed the present status of anticoagulant therapy in coronary artery disease and discussed the merits of treating the good risk patient without anticoagulant therapy, a subject which has been extensively discussed in medical literature. The problem always comes up, "How do you select a good risk patient?"

Dr. Huinagel described the present therapy in aortic insufficiency after discussing the differential diagnosis of etiology. He stated that he preferred cardiac arrest to total arrest and that his operation requires 30 minutes to one hour. He believes that the repair of the aortic valve itself is unsatisfactory and that the patient should have partial or total replacement of a valve. He uses a Teflon

prosthesis. His estimate was that in a good risk patient, the operative mortality is around 10 per cent; the over-all rate is 15 to 20 per cent. He said that the indications for surgery are progressive symptoms and the optimal time of operation is before uncontrollable failure sets in. He pointed out that in one month, eight patients with aortic insufficiency died before they were able to see him. He also stated that in mixed valve lesions, he operates on both valves at one sitting in the better risk patient.

Dr. Harry Gold, Professor of Clinical Pharmacology, Cornell University Medical College, New York City, reviewed the current aspects of diuretic therapy and the use of quinidine, on which he is an authority.

Dr. Frances L. Chamberlain, Clinical Professor of Medicine, University of California School of Medicine, San Francisco, discussed the management of patients with severe angina pectoris, reviewed the treatment and emphasized the use of the armchair in the treatment of severe acute coronary insufficiency. He pointed out that in a patient with coronary insufficiency of effort there is no evidence that exercise helps produce collateral circulation. He reviewed his E's for the patient with coronary insufficiency: To avoid, Exercise, Excitement, the Eating of bulk, Exposure to colds, Early morning hour activity, Ectopic rhythms, Epinephrine, Excessive thyroid, Exceptional altitude, and Excessive tobacco. Dr. Chamberlain expressed the opinion that it has been proved that anticoagulants are beneficial in acute coronary insufficiency to prevent infarction. He regarded desalting as helpful, especially in patients having nocturnal attacks of coronary insufficiency and hypertension.

Dr. Russek reviewed 100 young coronary patients and found that heredity was a factor in 67 per cent while in the control group it was a factor in 40 per cent. Of those with a high fat diet, 53 per cent were in the coronary group and 20 per cent in the control group. He stated that stress and strain were factors in 91 per cent of the coronary group and 20 per cent of the control group, and that obesity was a factor in 26 per cent of the coronary group and 20 per cent of the control group. One of the panelists pointed out that a person who had had an attack of coronary disease had more time to think about the factors of stress and strain than one who was well. Dr. Russek stated that of those using 30 cigarettes or more a day, 70 per cent were in the coronary group and only 35 per cent in the control group. Exercise was a factor in 58 per cent of the coronary group and 60 per cent of the control group.

Dr. Russek also discussed emotional stress in coronary heart disease in North American physicians, dentists and lawyers and attempted to illustrate that stress is a factor in the development of coronary heart disease and that the disease is more common in general practitioners than in physicians in what he called less rigorous specialties. Many of the panelists thought it was difficult to weigh all the factors involved. The question comes up, "Is there some similarity in the personalities of those who enter general practice and certain specialties?" It is noteworthy that in his stress paper he named four categories of physicians, dermatologists, pathologists, general practitioners and anesthesiologists, and classified general practitioners and anesthesiologists as a high stress group. He sent out 4,000 questionnaires and had a response from 60 per cent of them. It was his opinion that in his study group hypertension was not a factor in stress. He did believe that there is a difference in the possibility of developing coronary artery disease with stress on a low fat diet and stress on a high fat diet.

Dr. Chamberlain reviewed the advances and management of cardiac arrhythmias and pointed out that digitalis in arrhythmias blocks the atrioventricular node and strengthens the heart beat. He stated that the disadvantages of quinidine are increased atrioventricular conduction, bowel irritation, slow absorption, idiosyncrasy, and death from large doses, and that those of Pronestyl are irritation of the gastrointestinal tract, hypotensive effect, and death from rapid injection. In a patient with premature beats who has no heart disease, he estimated there is one chance in three that quinidine will not help. He outlined his treatment for paroxysmal supraventricular tachycardia as rest, carotid sinus pressure, administration of 7 cc. of Cedilanid intravenously if the patient is not digitalized, and administration of quinidine, 0.3 Gm. every two hours, until the episode stops. He pointed out that auricular flutter requires unusually large amounts of digitalis and at times even phenomenal amounts of this drug. With regard to the treatment of the Adams-Stokes syndrome, he mentioned that one patient has had an electrode in place for eight years. He believed the treatment of the Adams-Stokes syndrome consists of treating the underlying heart disease, administering ephedrine and Amytal, and reducing the

p

a

blood potassium with thiazide-like derivatives or steroids. It was his opinion that reducing the blood potassium improves the atrioventricular conduction.

Dr. James V. Warren, Professor and Chairman, Department of Medicine, Ohio State University College of Medicine, Columbus, Ohio, and President of the American Heart Association, pointed out in his address that he now believes the primary fuel of the heart muscle is probably lipids in the blood, and it has been established that ephedrine will raise the lipids of the blood. He also stated that it has been determined that oxygen demand is governed by the heart rate.

Digitalis, he said, probably has some effect on the normal heart muscle.

Dr. Earl K. Shirey, Cleveland Clinic Foundation, Department of Pediatric Cardiology and The Cardiac Laboratory, Cleveland, presented motion pictures of hearts using radiopaque material to show stenosis and insufficiency of valves before and after the insertion of Edwards-Starr valves. He also showed that certain vasodilators can dilate the coronary arteries.

This was one of the most informative and practical seminars held thus far by the local heart associations.

CHARLES K. DONEGAN, M.D. St. Petersburg

Deaths

Arms, Burdett Loomis, Haines City; born Sept. 27, 1869; University of Vermont College of Medicine, Burlington, Vt., 1905; specialized in Public Health laboratory work for many years, serving in the Boston Health Department, State Laboratory of Oregon, State Laboratory of Alabama, State Laboratory of Florida as Director, Public Health work in Idaho, and as County Health Officer of three counties in Maine; was State Health Officer in Florida from 1925 to 1929 and earlier had served as Professor of Preventive Medicine in Texas: upon retirement in 1946, returned to Florida to serve as Health Officer of Jefferson County for two years and then for 12 years as recorder of vital statistics in Polk County; died January 10, aged 94.

Forbes, Sherman Balch, Tampa; born in Plainwell, Mich., on Nov. 9, 1894; University of Maryland School of Medicine, Baltimore, 1918; interned at University Hospital, Baltimore, and served a residency at Baltimore Eye and Ear Hospital; during World War I, was in the United States Navy for five years and for two years prior to locating in Tampa was senior ophthalmologist and otolaryngologist for the Atlantic Fleet; began the practice of ophthalmology and otolaryngology in Tampa in 1922, but since 1944 had confined his practice to ophthalmology; spent a year in graduate study in Vienna in 1932 and again in 1937; made numerous contributions to the literature of his specialty; was a diplomate of the American Board of Ophthalmology and of the American Board of Otolaryngology; was a member of the American Medical Association, a member and past chairman of the Section on Ophthalmology and Otolaryngology of the Southern Medical Association, a member and past chairman of the Southern Section of the American Association for Research in Ophthalmology, a past president of the Florida Society of Ophthalmology and Otolaryngology, a life member of the American Academy of Ophthalmology and Otolaryngology, and a member of the International College of Surgeons; was a past president of the Hillsborough County Medical Association; was a member of the Investment Trust Committee of the Florida Medical Association; served as Consultant State Ophthalmologist and chairman of the Medical Advisory Committee to the Florida Council for the Blind, and as consultant to the National Society for the Prevention of Blindness, and chairman of its Professional Advisory Committee, Florida chapter; was a trustee of Stetson University; died June 25, aged 68.

Rask, Arthur Thomas, Lake Worth; born in Cleveland, Ohio, on May 23, 1908; Ohio State University College of Medicine, Columbus, 1937; interned at Saint Alexis Hospital, Cleveland, for one year and then served a two year residency at North Royalton Tuberculosis Sanitorium, North Royalton, Ohio, from 1938 to 1940; served from 1940 to 1942 in the U. S. Army Medical Corps with the rank of captain; engaged in the general practice of medicine and proctology from 1943 to 1952 in Cleveland and in Lake Worth thereafter; was a past president of the Palm Beach County Academy of General Practice; held membership in the American Medical Association, American

Academy of General Practice, Florida Academy of General Practice, Florida Proctologic Society and the World Medical Association; died June 30, aged 55.

Rezek, Philipp R., Miami, born in Vienna, Austria, on Aug. 23, 1894; University of Vienna Medical School, 1921; served an internship and residencies in Medical Clinics of Vienna; from 1933 to 1935 was Assistant Instructor of Neuropathology, University of Vienna Medical School; came to Miami in 1938, a refugee from the Nazis; in 1939 became the first full time pathologist at Jackson Memorial Hospital and served until his recent retirement as Director of the Department of Pathologic Anatomy there; when the University of Miami School of Medicine was established in 1953, became Professor of Pathology; was a distinguished lecturer and author of many scientific articles and co-author of the recently published medical text entitled "Autopsy Pathology;" in 1962 was guest lecturer in pathology at the Hebrew University in Jerusalem; was a diplomate of the American Board of Pathology in pathologic anatomy and was regarded as a medicolegal expert; held membership in the American Medical Association, College of American Pathologists, American Society of Clinical Pathologists, American Association of Pathologists and Bacteriologists, American Academy of Forensic Sciences. International Academy of Pathology, International Society for Gèographic Pathology, Florida Society of Pathologists and other scientific societies; died June 23, aged 68.

Guerra, Julio J., Clearwater; born in Havana, Cuba, on April 3, 1900; St. Louis University School of Medicine, St. Louis, Mo., 1928; served an internship at Tampa General Hospital, Tampa, in 1929 and after practicing in Tampa for a short time, engaged in postgraduate study at the Brady Urologic Clinic, New York City; returned to Tampa in 1933 where he practiced urology until 1951 when he relocated in Clearwater and continued the practice of his specialty there; held membership in the American Medical Association, Southern Medical Association, Florida Urological Society, Southeastern Urological Association and American Urological Association, and was a corresponding member of the Cuba Urological Association; died August 13 following lung surgery, aged 63.

Meetings

October

Florida Academy of General Practice, Fourteeenth Annual Scientific Assembly, October 10-13, Civic Center, Lakeland

Symposium on Medical Use of Radioisotopes, October 17, Hotel Americana, Bal Harbour, Miami Beach

Postgraduate Symposium in Orthopaedics, Trauma, Minor Surgery and Office Orthopaedics, October 17-19, Auditorium, Mound Park Hospital, and Clinic, American Legion Hospital for Crippled Children, St. Petersburg Florida Society of Anesthesiologists, October 19-20, Sheraton-Tampa Motor Inn, Tampa

Florida Orthopedic Society, Fall Meeting, October 25-27,

Port Paradise Hotel, Crystal River

Florida Society of Pathologists, Annual Meeting, October 31-November 3, Ponce de Leon Motor Lodge, St. Augustine

November

Florida Radiological Society, Fall Meeting, November 1-3, Far Horizons, Longboat Key, Sarasota

Seminar in Diagnosis of Cardiac Arrhythmias, November 1-4, Tampa General Hospital, Tampa

Fourth Annual Medical Seminar Cruise, November 23-30, M S Riviera from Fort Lauderdale, University of Florida College of Medicine, Gainesville

Florida State Surgical Division, International College of Surgeons, Fourth Annual Fall Meeting, November 29-30, University of Florida College of Medicine, Gaines-

American Fracture Association, 24th Annual Meeting, November 10-15, Hotel Americana, Bal Harbour, Miami Beach

Florida Pediatric Society, Fall Meeting, November 14-17, Grand Bahama Hotel, West End, Bahamas

December

American Medical Association, 17th Clinical Meeting, December 1-4, Memorial Coliseum, Portland, Ore.

Florida Obstetric and Gynecologic Society, Fall Meeting, December 6-8, Grand Bahama Hotel, West End, Bahamas

Books Received

Clinical Examinations in Neurology. By Members of the Sections of Neurology and Section of Physiology, Mayo Clinic and Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota. Ed. 2. Pp. 396. Illustrated. Price \$8.50. Philadelphia, W. B. Saunders Company, 1963. Diseases of the Chest. By H. Corwin Hinshaw, M.D.

Diseases of the Chest. By H. Corwin Hinshaw, M.D., Ph.D., D.Sc., and L. Henry Garland, M.B., B.Ch., M.D. Ed. 2. Pp. 798. Illustrations 743 on 308 Figures. Price \$20.00. Philadelphia, W. B. Saunders Company, 1963.

Organization and Administration in World War II. Medical Department, United States Army. Prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. Editor in Chief, Colonel John Boyd Coates, Jr., MC, USA. Editor for Organization and Administration, Charles M. Wiltse, Ph.D., Litt. D. Pp. 613. Illustrated. Washington, D.C., Office of the Surgeon General, Department of the Army, 1963.

Synopsis of Ear, Nose, and Throat Diseases. By Robert E. Ryan, B.S., M.D., M.S. (ALR), F.A.C.S., William C. Thornell, A.B., B.M., M.D., M.S. (ALR), F.A.C.S., and Hans von Leden, M.D., FA.C.S., F.I.C.S. Ed. 2. Pp. 425. Illustrated. Price \$7.50. St. Louis, The C. V. Mosby Company, 1963.

Optokinetic Nystagmus; Its Use in Topical Neuroophthalmologic Diagnosis. By J. Lawton Smith, M. D. Pp. 141. Illustrated. Price \$6.75. Springfield, Ill., Charles C. Thomas, Publisher, 1963.



The Lady Governors of the Old Men's Home at Haarlem

FRANS HALS, 1580/81-1666

In Geriatrics...

METAMUCIL® Provides Bland Smoothage

brand of psyllium hydrophilic mucilloid

The tendency of the elderly to subsist on low-residue foods often is a prime cause of bowel sluggishness. Adequate fecal content is necessary to maintain normal colonic function, since intracolonic distention is nature's method of stimulating reflex peristalsis.

Metamucil, therefore, fulfills a basic function in the treatment of geriatric constipation. It both softens hard, dehydrated fecal concretions and adds smooth, nonirritant, easily compressible hydrophilic bulk.

Metamucil applies a physiologic principle to correct constipation naturally.

Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. To Metamucil powder, a re-

fined, purified and concentrated psyllium hydrophilic mucilloid, an equal amount of dextrose is added as a dispersing agent. Each dose of the powder furnishes a negligible amount of sodium and 14 calories. To the mucilloid in Instant Mix Metamucil citric acid, sodium bicarbonate and mild flavoring are added. Each dose of Instant Mix Metamucil furnishes 0.25 Gm. of sodium and 3 calories. Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

G. D. SEARLE & CO.

CHICAGO, ILLINOIS, 60680

Research in the Service of Medicine

J. Florida M.A./October, 1963 299

Announcing

THE TWENTY-FOURTH ANNUAL MEETING OF

THE AMERICAN FRACTURE ASSOCIATION

November 10-15, 1963 — Americana Hotel

Miami Beach, Florida

A highlight of the meeting will be a symposium on Fracture Fundamentals to be presented by Wallace E. Miller, M.D., Chairman, Department of Orthopaedics, University of Miami School of Medicine and his staff.

OTHER GUEST SPEAKERS

Hugh Burke, D.D.S., Dixon, Ill.
Alexander Kushner, M.D., Miami, Fla.
Joseph C. Flynn, M.D., Orlando, Fla.
Joseph G. Matthews, M.D., Orlando, Fla.
Herbert W. Virgin Jr., M.D., Miami, Fla.
A. H. Diehr, M.D., St. Louis, Mo.
Philip T. Holland, M.D., Bloomington, Ind.
John E. Burch, M.D., Miami, Fla.
J. Gordon McAllister, M.D., Fort Lauderdale, Fla.
George Garceau, M.D., Indianapolis, Ind.
Robert W. Bailey, M.D., Ann Arbor, Mich.
William Price, M.D., Houtson, Texas
George R. Ruiz, M.D., Martinsburg, W. Va.
Harold O. Hallstrand, M.D., S. Miami, Fla.
Nathan E. Baer, M.D., Monroe, Wisc.
William Johnson, M.D., Galesburg, Ill.
George F. Pennal, M.D., Toronto, Canada
Donald Y. Stewart, M.D., Riverhead, N.Y.
Benjamin I. Golden, M.D., Elkins, W. Va.
Parviz Kambin, M.D., Elkins, W. Va.

Martin Dobelle, M.D., Washington, D. C. Robert Elliott, M.D., Houston, Texas Leo Cooper, M.D., Gary, Ind.
Joel E. Adams, M.D., San Bernardino, Calif. C. Philip Fox, M.D., Washington, Ind.
Irvin H. Scott, M.D., Sullivan, Ind.
Augusto Sarmiento, M.D., Miami, Fla.
Joseph Kalbac, M.D., Miami, Fla.
Harvey E. Billig Jr., M.D., Los Angeles, Calif. Charles F. Woodhouse, M.D., Chicago, Ill.
Arthur A. Michele, M.D., New York, N. Y.
Roger Anderson, M.D., Seattle, Wash.
Capt. Thomas J. Canty, Camp Pendleton, Calif. R. Fernandez Torres, M.D., Caracas, Venezuela Earl McBride, M.D., Oklahoma City, Okla.
Jorge B. Colon, M.D., Ponce, Puerto Rico
Michael P. Mandarino, M.D., Philadelphia, Pa.
Harold A. Fenner, M.D., Barquisimeto, Venezuela

Lectures, round-table luncheon discussions, Medical motion pictures, technical exhibits, scientific exhibits, and entertainment for visiting wives.

For further information concerning the meeting write Joseph J. Ruskin, M.D., Program Chairman 204 Palm Avenue, Tampa, Florida

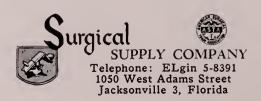
Proctologic Aid

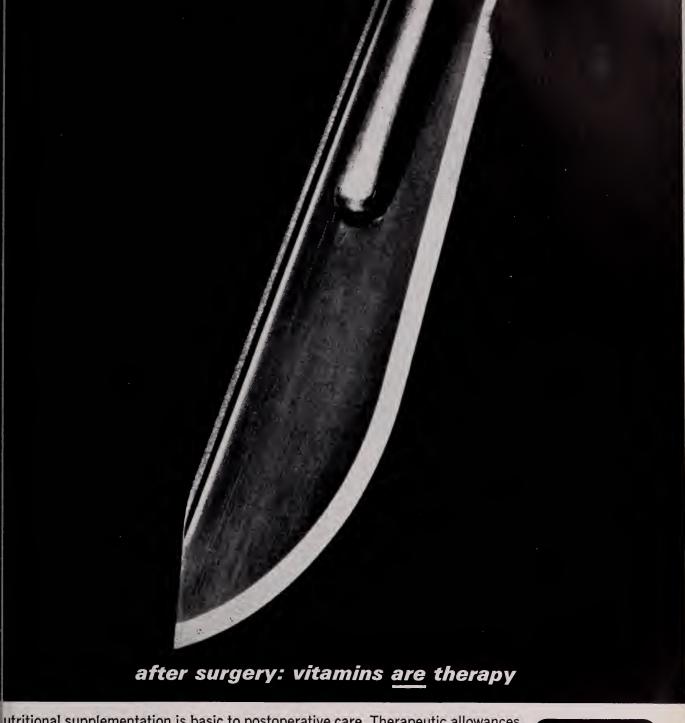
PROCTO-REST is a simple device that provides a full measure of convenience in sigmoidoscopy procedures. It is designed to establish and maintain correct positioning of the patient. Its sturdy construction and formed padding provide comfort and induce relaxation.

Takes only seconds to unfold. Has locking bracket for complete safety. Can be used on any examining table.



Folds compactly for storage. Fits into the base of the examining table or a storage cupboard. Supplied in gray, white or brown upholstery.





utritional supplementation is basic to postoperative care. Therapeutic allowances B and C vitamins help meet increased metabolic requirements and compensate r stress depletion. STRESSCAPS can set the patient on a more favorable course nd contribute to full recovery.

ch capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 10 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin C (Pyridoxine HCl)...2 mg. / Vitamin C (Ascorbic Acid)...300 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin ficiencies. Supplied in decorative "reminder" jars of 30 and 100.



Rederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

Stress Formula Vitamins Lederle

News

The Fourth Annual Fall Meeting of the Florida State Surgical Division of the International College of Surgeons is being held November 29-30 at the University of Florida College of Medicine in Gainesville. The program begins at 1:00 p.m. in the Medical Sciences Building.

A postgraduate course in Physiology and Pathophysiology in Clinical Cardiology conducted by Dr. James V. Warren of Columbus, Ohio, will be presented November 18-22 at the Mount Sinai Hospital of Greater Miami. Evening sessions will begin at 8:00 p.m.

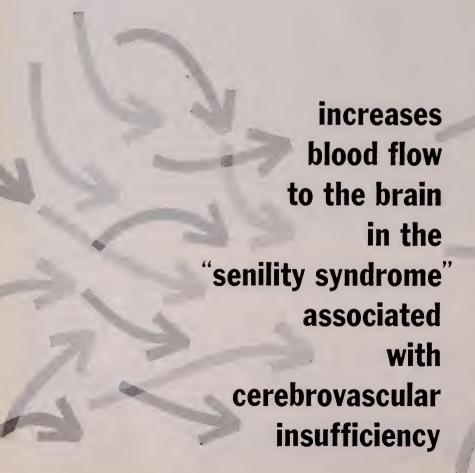
A special Conference on Oral Cancer for members of the medical and dental professions in Florida has been scheduled for Tuesday, October 8, at the Hotel Fontainebleau on Miami Beach.

Dr. Clifford C. Snyder of Coral Gables and Dr. Nelson Zivitz of Miami Beach have been appointed co-chairmen of the local Committee on Arrangements for the Clinical Meeting of the American Medical Association being held November 29-December 2, 1964, at Miami Beach. Members of the Escambia County Medical Society joined with the various hospitals in Pensacola in helping to equip a clinic in the coastal town of Chimbote, north of Lima, Peru. With assistance from drug and medical supply firms, not only will a clinic be established but a medical program will be initiated in the area.

The Annual Meeting of the Florida Society of Pathologists will be held October 31-November 3 in the Ponce de Leon Motor Lodge at St. Augustine.

Dr. Zack Russ Jr. of Tampa has been appointed to the Advisory Board of the Unit for Psychotic Children which is to be established at the University of Florida in Gainesville. Dr. William D. Rogers of Chattahoochee has been reappointed Director of the Division of Mental Health of the State of Florida, and Dr. James B. O'Connor has been appointed superintendent of Florida State Hospital at Chattahoochee.

The Fall Meeting of the Florida Obstetric and Gynecologic Society will be held at the Grand Bahama Hotel in the Bahamas on December 6-8.





Dr. Edward R. Annis of Miami, President of the American Medical Association, and Dr. Warren W. Quillian of Coral Gables, President of the Florida Medical Association, are among the speakers on the program for the 7th annual convention of the American Association of Medical Assistants being held October 9-13 at Miami Beach.

The 17th Clinical Meeting of the American Medical Association is scheduled for December 1-4 at Portland, Ore. Most of the scientific sessions and all the scientific and industrial exhibits will be in Memorial Coliseum.

The Twenty-Fourth Annual Meeting of the American Fracture Association will be held in the Americana Hotel at Miami Beach November 10-15. Dr. Joseph J. Ruskin of Tampa is program chairman. The list of guest speakers may be found in this issue of The Journal.

More than 25 speakers will present the program for the 14th Annual Scientific Assembly of the Florida Academy of General Practice being held at Lakeland October 10-13. It was been accepted for 16 hours of Category I credit by the American Academy of General Practice.

Patronize Your

Independent X-ray Dealer

He'll be around when you need him

BOB WAGNER X-RAY

P. O. Box 8161 Jax 11, Florida RA 4-3434.

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS. A. H. DUVALL GLENWOOD, FLORIDA



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems. 1-3

43% increase in cerebral blood flow4

In patients with cerebrovascular insufficiency, Eisenberg⁴ measured a 43 percent increase in blood flow in the brain following administration of Arlidin (nylidrin HCl) orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

Winsor and associates³ found Arlidin (nylidrin HCI) "of particular value clinically in relieving some of the symptoms of cerebral vascular insufficiency (vertigo, lightheadedness, mental confusion, diplopia)."

arlidin[®] BRAND OF NYLIDIN HCI

SUMMARY: Indicated whenever an increase in blood supply is desirable in circulatory insufficiencies of the extremities, brain, eye and ear. Use with caution in the presence of a recent myocardial lesion, severe angina pectoris and thyrotoxicosis. Contraindicated in acute myocardial infarction.

REFERENCES: 1. Madow, L.: Penn. M. J. 62-861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Labs., division • 800 Second Avenue, New York 17, N. Y.





Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets before meals and at bedtime. Individualization required.

Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / Cranbury, N. J.

FOR RENT: Complete office. Ready to move into in the Doctors Building. \$110. per month including air-conditioning, heat, hot water and janitor service. Downtown location, abundance of free parking for patients. Contact S. J. Wilson, M.D., 309 N. E. River Drive, Fort Lauderdale. Fla.

WANTED: General Practitioner, Internist, Pediatrician, to join surgeon in new clinic. Exciting growth enterprise in finest Cape Canaveral location. Arrangements open. Write 69-484, P.O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN WANTED: For association in Hollywood, Fla. Must be Board qualified or certified. For information contact Medical Business Consultants, 1101 N.E. 79th St., Suite 205, Miami, Fla. Telephone PL 9-0230.

WANTED: Pediatrician, ENT, Internist and Dermatologist for new medical building ready Feb. 15. Adjacent to hospital in beautiful location on Gulf of Mexico. Fine practice opportunity. Write 69-510, P.O. Box 2411, Jacksonville, Fla.

MEDICAL OFFICE AVAILABLE: Unusual opportunity for GP or specialist in Miami Beach. Call Jefferson 1-1246 or contact: Dr. Leonard Sakrais, 1500 Bay Rd., Miami Beach, Florida.

GENERAL PRACTITIONER: New professional office for rent Cocoa, Fla. 1,200 sq. ft. floor space. Designed for physician. Wired for X-ray. Nicely paneled personal office and waiting room. 5 examining rooms each equipped with wash basin. Laboratory. Central air-conditioning system with reverse cycle for central heat. Adjoining new upper class 30 unit furnished apartment complex. Ground floor corner location with exterior professional design. Ample parking. 3 separate entrances. Choice location in fastest growing county in U.S. For information call A. A. Annis, Newton 6-1872 or write P.O. Box 6, Cocoa, Fla.

AVAILABLE: For \$90 enjoy professional suite of 4 rooms air-conditioned in Medical Arts Building, 503 W. Platt, Tampa. Phone 251-1600.

FOR SALE OR LEASE: Physician in Highlands section retiring from active practice. Will sell or lease. Write 69-546, P.O. Box 2411, Jacksonville, Fla.

INTERNIST WANTED: Large multi-specialty group in Florida desires to add a sixth internist to its department of Internal Medicine. Applicant should be 35 years of age or under and board eligible. Write 69-544, P.O. Box 2411, Jacksonville, Fla.

INTERNIST WANTED: For association in group practice. No investment necessary. Gastroenterology training desirable. Academic, financial, personal satisfaction. Beautiful area. Fine hospitals. Modern, completely equipped medical building. Write 69-542, P.O. Box 2411, Jacksonville, Fla.

SURGEON: Desires relocation in solo or group in Florida. Have Florida license, ACS and Board qualified. Will do some general practice. Write full details first letter. Write 69-534, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Office equipment of deceased G.P. Includes 2 Ritter examining tables, Burdick III EKG, Leitz Colorimeter, Adams Centrifuge, Diathermy, Welch-Allyn Oto-Ophthalmoscope, W-A procto-sigmoidoscope, Hyfrecator, Standby Baumanometers, and many other items. All purchased new and in excellent condition, with 2 years' use. Mrs. J. H. Wachal, Cross City, Fla.

PEDIATRICIAN WANTED: Florida license. \$1000 minimum monthly guarantee first 6 months or 40% of income. Second 6 months 45% and full partnership after one year. Large income now. May be expected to increase considerably with complete coverage of vacation and days off. Write 69-547, P.O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN WANTED: For association in present two man partnership. East coast Florida town. Prefer FAAP or Board eligible. Write full particulars in first letter. Write 69-548, P.O. Box 2411, Jackson-

GENERAL PRACTITIONER WANTED: To join Clinic in Lake County, Florida. Write P.O. Box 546, Mount Dora, Florida.

RESIDENCE - PROFESSIONAL OFFICE, UN-FURNISHED: For attractive Florida living and pleasant working with generous income tax considerations, this is the place. Centrally located; choice section; corner location. Five room office suite with lavatory; five large rooms in residence segment, 2 baths. Central air conditioning; radiant heating in tile floors throughout. Spacious attic storage. Office accommodates busy practice; courtyard affords ample parking. Separate large garage and air conditioned guest house with comfortable Florida room, bedroom, kitchen, bath. Carport. Entire property (3 city lots) is enclosed by wall and three wrought iron gates. Pool in large patio; artistic barbecue. Long sundeck overlooks pool, patio, and Japanese-like gardens; beautifully land-scaped for minimal maintenance. \$85,000 (two thirds cost); \$45,000 mortgage available. Write Meredith Campbell, 1501 South Miami Avenue, Miami, Florida.

GENERAL PRACTITIONER WANTED: Two members of A.A.G.P. have excellent opening for qualified man. Essentially solo practice within a group; no investment necessary. Write 69-549, P.O. Box 2411, Jacksonville, Fla.

WANTED: Generalist with interest in surgery and obstetrics; and also Pediatrician to join well established two man partnership clinic in central Florida lake region. Full diagnostic facilities in clinic and hospital affiliation assured. Salary to start with partnership to follow, if mutually acceptable. Write 69-550, P.O. Box 2411, Jacksonville, Fla.

WANTED: Pediatrician for association with two obstetricians. Office space, basic equipment and guaranteed income are available for an acceptable man. Write 69-551, P.O. Box 2411, Jacksonville, Fla.

PRACTICE FOR SALE: Excellent general practice and equipment, Fort Myers proper, established 17 years same location. Contact: Curtis R. House, M.D., 2203 McGregor Blvd., Fort Myers, Fla.

WANTED: Associate by busy general practitioner. Excellent remuneration to start with full partnership after one year. No investment necessary. Write 69-552, P. O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER wanted for full time group practice in Central Florida in Fall of 1963. This is a large established practice in pleasant community. Please send resume to 69-543, P.O. 2411, Jacksonville, Fla.

WANTED: Nose and throat man, Obstetrician, Dermatologist, Internal Medicine. Arrangements open. Growing community. Phone John O. Rao, M.D. 847-2833, Kissimmee, Fla.

OFFICE SPACE FOR RENT: Medical suite, approximately 600 sq. ft. in separate consultation, two treatment and laboratory rooms. Share secretary and reception room. New professional building, excellent furnishings. Suitable for specialty or general practice. Clarence H. Schilt, M.D., 2161 McGregor Bldg., Ft.

WANTED: General Practitioner for Clinic-Hospital. Salary open—plus bonus. Write 69-535, P.O. Box 2411, Jacksonville, Fla.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 3. This service is for the use of physicians seeking locations, as well as physicians seeking associates.

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however,

> it should be used with care on patients



parenteral hemostat

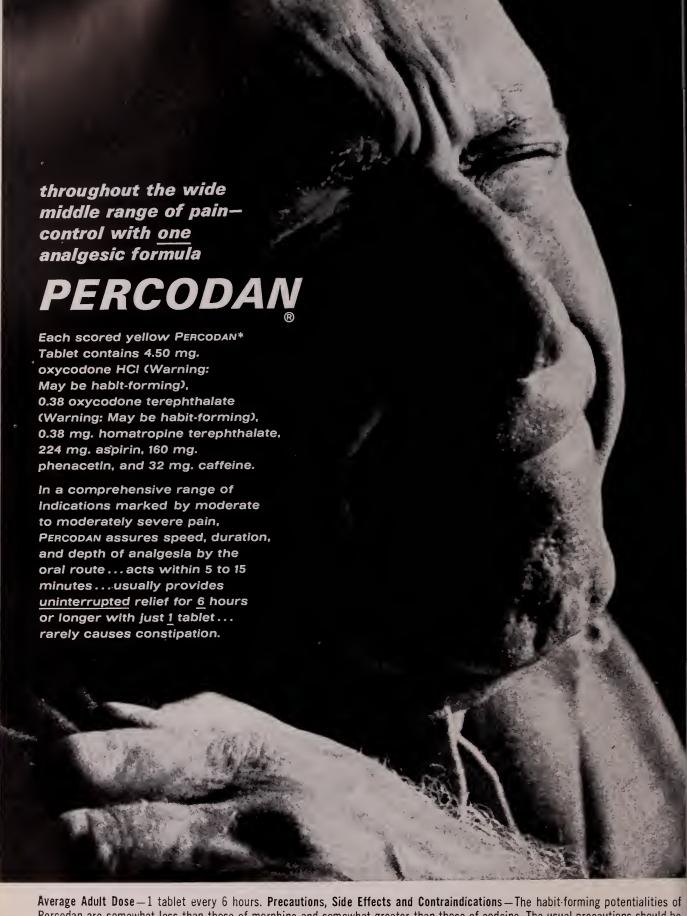
Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer. Complete data with each 10cc vial. Therapy chart on request.



hatham CHATHAM PHARMACEUTICALS, INC.

Newark 2, New Jersey

Distributed in Canada by Austin Laboratories, Ltd. • Paris, Ontario



Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, Percodan may cause nausea, emesis, or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. Also available: Percodan®-Demi, containing the complete Percodan formula but with only half

the amount of salts of oxycodone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. Literature on request. ENDO LABORATORIES Richmond Hill 18, New York



For dramatic restoration WINSTROL® brand of STANOZOLOL

Oral anabolic therapy with this new physiotonic helps restore the patient's: positive protein metabolism; confidence, alertness and sense of well-being.

WINSTROL (stanozolol/Winthrop), a heterocyclic steroid, combines highest potency* with outstanding tolerance, stimulates appetite and promotes weight gain...restores a positive metabolic balance. It counteracts the catabolic effects of concomitant corticosteroid or ACTH therapy. WINSTROL (stanozolol/Winthrop) rebuilds body tissue while it builds strength, confidence and a sense of well-being in conditions associated with excess protein breakdown, insufficient protein intake and inadequate nitrogen and mineral retention.

Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible, and patients receiving prolonged treatment should be examined and questioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time.

In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (preschool age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

Rx WINSTROL
(stanozolol/Winthrop) whenever
anabolic therapy is indicated

Winthrop

Winthrop Laboratories, New York 18, New York



eczema and problem feeding.

SOYALAC helps solve the feeding problem of prematures and infants requiring milk-free diet.

Strikingly similar to mother's milk in composition and ease of assimilation, babies thrive on SOYALAC.

Clinical data furnish evidence of SOYALAC'S value in promoting growth and development.

Protein of high biologic value is obtained from the soybean by an exclusive process.

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information, and a supply of samples.

Medical Products Division

LOMA LINDA FOODS

RIVERSIDE, CALIFORNIA Mount Vernon, Ohio . Oshawa, Ontario-Canada



"They keep saying I'm sloppy!"



Nicozol® helps you restore your geriatric patients' interest in themselves

NICOZOL therapy can help you brighten the outlook of your aging patients who tend towards (1) untidiness, (2) irritability, (3) incompatibility, (4) lack of interest, and (5) loss of memory or alertness.

The NICOZOL formula helps improve mental acuity, increase the supply and use of oxygen in the brain, improve peripheral circulation—without excitation, depression, or other untoward effects.

NICOZOL can help you keep your aging patients actively alert and at ease with themselves, their families, and others.

Supplied: NICOZOL tablets (and capsules) in bottles of 100 and 1000. NICOZOL elixir in pints and gallons.

Precautions: May produce overstimulation in high doses. Discontinue if muscular twitchings or clonic convulsions occur. The flush produced in sensitive individuals is transient and harmless.

Average Dose: 1 to 2 tablets (or capsules) 3 times a day. 1 teaspoonful elixir 3 times a day.

Formula: Each tablet or capsule contains:

•	Lacii tablet of capsule contains.
	Pentylenetetrazol100 mg.
	Nicotinic Acid 50 mg.
	Each teaspoonful (5 cc.) elixir contains:
	Pentylenetetrazol200 mg.
	Nicotinic Acid
	(as the sodium salt)
	Alcohol
	• •

HART

Division of A. J. Parker Co. LABORATORIES Bryn Mawr, Pa., Winston-Salem, N.C. **NICOZOL**®

Only Fleischmann's offers these four benefits in a "special" margarine

- 1. Exceptionally high polyunsaturated to saturated fat ratio well within the American Medical Association's definition of a "special" margarine.*
- 2. Extraordinarily delicious taste . . . so outstanding it's made Fleischmann's the country's largest selling corn oil margarines.
- 3. Lightly Salted and Unsalted . . . yes, Fleischmann's Margarine comes Lightly Salted and Unsalted. And both Fleischmann's Margarines are made from 100% golden corn oil . . . over one half of which is liquid corn oil.
- **4.** National availability . . . unlike most competitive brands, Fleischmann's Corn Oil Margarines are in practically every grocery and supermarket throughout the country . . . at a price your patients can easily afford.

Because only Fleischmann's Margarines offer all four benefits in a "special" margarine, they're the most practical choice for your high cholesterol and low-sodium patients. Fleischmann's combines the delicious flavor your patients and their families will love with the highest polyunsaturates to saturates ratio of the nation's leading margarines. Fleischmann's taste advantage makes it much easier to keep patients on a therapeutic diet.

Fleischmann's polyunsaturated to saturated fat ratio is 1.7 to 1 (27.5% cis, cis linoleic acid), this is higher than many so-called "corn oil" margarines which are a mixture of hardened cottonseed and soybean oils with corn oil. However, the only oil used in Fleischmann's is 100% corn oil. Half of Fleischmann's corn oil is in liquid form for high linoleic content... the balance is partially hydrogenated for flavor and spreadability.

In line with A.M.A. Report—Using Fleischmann's Lightly Salted Margarine instead of butter or regular margarines increases your patients' intake of polyunsaturates...while lowering their intake of saturated fat. This is in line with the A.M.A. Report on Dietary Fat Regulation in managing atherosclerosis.*

310



Fleischmann's Lightly Salted Margarine—So when you recommend a regulated fat diet ... remember Fleischmann's Lightly Salted Margarine . . . the ideal "special" margarine. It's high in polyunsaturates . . . lowest in saturated fat of the nation's leading margarines.



Fleischmann's Unsalted Margarine—Also made from 100% corn oil, Fleischmann's Unsalted Margarine is dietetically sodium-free—ideal for the patient who needs sodium restriction. It has the same high P/S

value as Fleischmann's Lightly Salted Margarine. And because it contains no salt—or preservative of any kind—Fleischmann's Unsalted Margarine is kept in the grocer's frozen food section.

*Council on Foods and Nutrition of the American Medical Association. J.A.M.A., <u>179</u>, 719, 1962. J.A.M.A., 181, 139, 1962.



... nothing, that is, except the sedative-antispasmodic action of

No serious toxic reactions are to be anticipated. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage, but promptly disappear with reduction in dosage. Contraindicated in acute glaucoma, advanced hepatic or renal disease, or idiosyncrasy to any component. Use with care in incipient glaucoma or urinary bladder neck obstruction.

A. H. ROBINS CO., INC., Richmond 20, Virginia

onnatal 🎏



In each Tablet, Capsule or 5 cc. Elixir Extentab 0.1037 mg. 0.3111 mg. hyoscyamine sulfate 0.0194 mg. 0.0065 mg. 0.0582 mg. atropine sulfate 0065 mg. hyoscine hydrobromide 0.0195 mg. 16.2 mg. (¼ gr.) phenobarbital (¾ gr.) 48.6 mg. (Warning: May be habit forming) Prescribed by more physicians than any other antispasmodic—well over 5 billion doses!



call for analgesic-relaxant action ...

Whether spasm is induced by pain, or pain by spasm, satisfactory control usually requires analgesic as well as relaxant action. In such cases, Robaxisal combats both pain and spasm. When apprehension is a complicating factor, Robaxisal-PH is indicated.

Among the many conditions for which ROBAXISAL and ROBAXISAL-PH have been found effective are: strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, low back pain, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may infrequently occur but usually disappear on reduction of dosage. There are no specific contraindications other than hypersensitivity to any one of the components.

*Skeletal muscle spasm is a two-headed dragon of 'PAIN & SPASM'

ROBAXISAL

Each pink-and-white laminated Tablet contains:

ROBAXIN (methocarbamol, Robins)... 400 mg.

U.S. Pat. No. 2770649



ROBAXISAL-PH

Each green-and-white laminated Tablet contains:

 ROBAXIN (methocarbamol, Robins)
 400 mg.

 Phenacetin
 97 mg.

 Aspirin
 81 mg.

Hyoscyamine sulfate 0.016 mg. Phenobarbital (1/8 gr.). 8.1 mg. (Warning: May be habit forming)



A. H. ROBINS CO., INC., Richmond 20, Virginia

CHOOSE THE PRODUCT TO FIT THE NEED



a <u>new</u> vanishing cream base



'CORTISPORIN'

POLYMYXIN B - BACITRACIN - NEOMYCIN WITH HYDROCORTISONE 1%

OINTMENT



a special low melting point base

anti-inflammatory bactericidal antipruritic rarely sensitizing

CREAM-Ingredients: Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5.0 mg.; Gramicidin 0.25 mg.; Hydrocortisone Acetate 5.0 mg. (0.5%).

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT-Ingredients: Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 500 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and % oz.

*U.S. Patent Nos. 2,565,057-2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.



Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



added capabilities in a cardiograph . . . with the Sanborn "100 Viso"

All electrocardiographs produce a graphic record to aid you in your diagnosis, but the Sanborn "100 Viso" and its mobile "100M" version add two significant capabilities to this basic ECG function: com-





plexes can be "expanded" in time by running the chart at 50 mm/sec. instead of 25 mm/sec., and amplitude or height of the tracing can be adjusted to suit the leads being recorded (sensitivity can be set at normal, one-half normal or twice the normal value). Provision is also made for connecting a scope for signal display, and for recording other physiologic phenomena.

Coupled with world-famous Sanborn cardiograph dependability, precision and locally-available supplies — and the exclusive 15-Day No-Obligation Trial Plan — these 100 and 100M Viso-Cardiette advantages can make a significant difference in ECG value to you. Your nearby Sanborn man can provide full details, or write the main office.

SANBORN COMPANY

Medical Division, Waltham 54, Mass.

MIAMI Branch Office 2907 N. W. 7th St., 305 635-6461
St. Petersburg Resident Representative
337 22nd Ave. N., 862-3229

Jacksonville Resident Representative
2720 Park St., 384-3453

HCV CREME

3% Iodochlorhydroxyquin

1% Hydrocortisone

Provides ANTIFUNGAL, ANTIBACTE-RIAL, ANTI-INFLAMMATORY AND AN-TIPRURITIC action in dermatitis.

GEVIZOL

Each 5 cc. tspfl or tablet provides 100 mg. Pentylenetetrazol, 50 mg. Nicotinic acid. GEVIZOL is indicated in the treatment of the mentally confused, emotionally unstable, apathetic aged and aging patient. For the patient complaining of dizziness or fogginess. Reactivates the inactivated.

PHARMACAL
CORPORATION

St. Petersburg

Florida

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Avenue, N. E. St. Petersburg, Florida Phone 862-6903



314B John Ringling Blvd Sarasota, Florida Phone 388-1604

> Box 514 Miami 62, Florida Phone 945-4055

Affiliates of Black & Skaggs Associates Battle Creek, Michigan



Out-Patient Clinic and Offices

James A. Becton, M.D.

James Keen Ward, M.D.

P. O. Box 2896, Woodlawn Station, Birmingham 6, Ala. Phone WO 1-1151 and WO 1-1152



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

- 1. A sprain or fracture is not a big clinical problem but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.
- 2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains-and more potent products too often make the patient feel 'dopey'.
- 3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness ("numbs the pain...not the patient").

- 4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.
- 5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

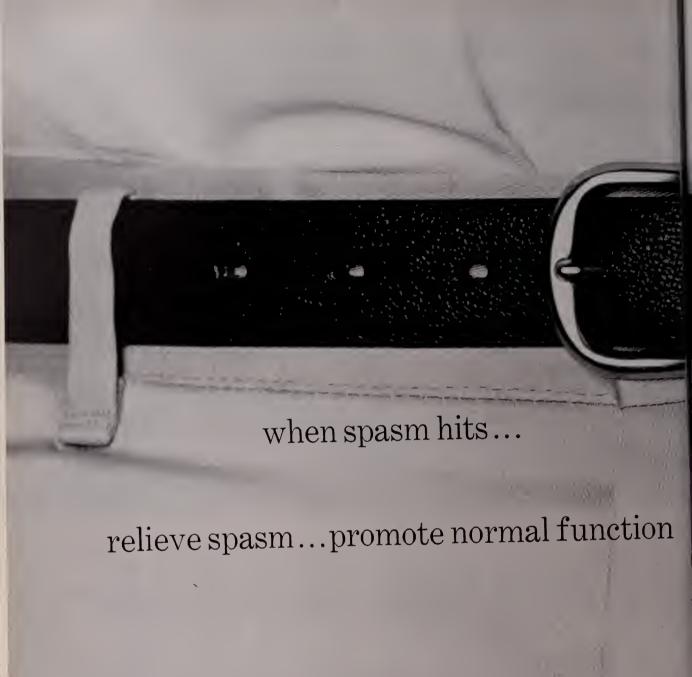
Soma Compound carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.



Soma Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning - may be habit forming.)

WeWALLACE LABORATORIES / Cranbury, N. J.





Sustained Release Capsules TRIDIHEXETHYL CHLORIDE Each capsule contains: Tridihexethyl chloride...75 mg.; Phenobarbital...45 mg.

nulated for controlled release of the active edients, for sustained anticholinergic proon against spasm and pain in the G.I. tract. ell as sustained phenobarbital action.

linates the necessity for numerous doses; ens out "peaks and valleys" in drug blood s that can minimize effectiveness; and rees protective medication through the night. ctive in organic and functional disorders ne gastrointestinal tract (duodenal ulcer, stinal colic, ileitis, esophageal spasm, stinal spastic colon, alcohol-induced G.I. ets, gastric hypermotility) and anxiety neurosis with G.I. symptoms. Should be used as an adjunct to other measures. Side Effects due to tridihexethyl chloride: dry mouth, blurring of vision, constipation. Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention. Supply: Bottles of 30 and 500.

Also available: PATHILON SEQUELS (without phenobarbital) Tridihexethyl chloride, 75 mg. Bottles of 30 and 500.



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, N.Y.

Look into her eyes... She needs iron, too

PANTRINSIC-C

with Cobalt, Vitamin C and Hesperidin NON-CONSTIPATING • NO G.I. UPSET • NO DIARRHEA

Ideally suited for pregnant patients

Each Two PANTRINSIC-C, round, pink tablets S.C. contain:

Ferrous Fumarate	300 mg.
Hesperidin2	250 mg.
Ascorbic Acid	250 mg.
Cobalt Chloride	10 mg.
Stomach Substance	100 mg.
Whole Liver	200 mg.
Thiamine HCl	.5 mg.
Vitamin B-12	. 5 mcg.

Indications: For iron deficiency and anemias associated with blood loss.
• Malnutrition. • Pregnancy, etc.

Dose: Just two tablets daily. Available: In bottles of 100 and 500 tablets.



Write for samples and literature...

THE BROWN PHARMACEUTICAL COMPANY
2500 West Sixth Street, Los Angeles 57, California



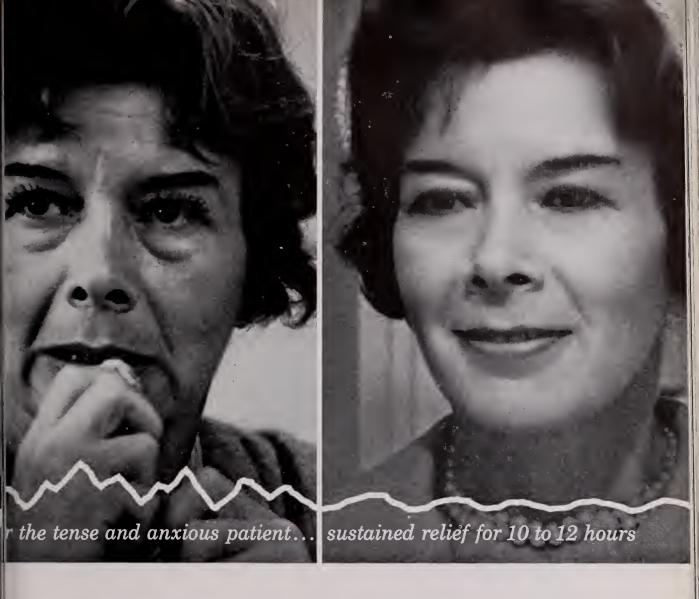
TUCKER HOSPITAL, INC.

212 West Franklin Street RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological patients. Hospital and out-patient services.

(Organic diseases of the nervous system, psychoneuroses, psychosomatic disorders. mood disturbances, social adjustment problems, involutional reactions and selective psychotic and alcoholic problems.)

Dr. James Asa Shield Dr. George S. Fultz, Jr. Dr. Weir M. Tucker Dr. W. Frederick Young



mooths out emotional peaks and valleys

prospan'-400 brand of meprobamate contains 400 in sustained-release form. One capsule smooths the anxious patient's emotional peaks and valleys 10 to 12 hours — and provides these other advances:

'atients whose anxiety has diminished to a mild r moderate level still require a certain amount of ranquilization throughout the day. Sustained-repasse action is ideally suited to this type of patient.

impler dosage schedule. Since one capsule of Meprospan'-400 (meprobamate, sustained release) at 10 to 12 hours, the patient enjoys a much impler dosage schedule than with tablets — and s less likely to forget to take the medicine.

e Effects: Rarely, skin reactions. May increase cts of excessive alcohol. Use with care in patients

with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: 'Meprospan'-400 (meprobamate, sustained release) contains meprobamate 400 mg. 'Meprospan'-200 (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. Usual dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Meprospan-400 meprobamate 400 mg.

sustained release

WALLACE LABORATORIES / Cranbury, N.J.,

BRAWNER HOSPITAL, INC.

(Established 1910)

2932 South Atlanta Road, Smyrna, Georgia

FOR THE TREATMENT OF PSYCHIATRIC ILLNESSES
AND PROBLEMS OF ADDICTION
MODERN FACILITIES

Jas. N. Brawner, Jr., M.D.

Medical Director

ALOYSIUS I. MILLER, M.D. MARK A. GOULD, M.D.

Phone HEmlock 5-4486



P. L. DODGE MEMORIAL HOSPITAL

formerly

MIAMI MEDICAL CENTER

M. G. ISAACSON, M.D. Medical Director and President

1861 N.W. South River Drive Phone 379-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including — Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities.

Information on request Member NAPPH and American Psychiatric Assn.



ADVANTAGES -

Chelated Iron PLUS 4 Chelated Minerals
• High Therapeutic Effectiveness • Less
Irritation — even on empty stomach •
No Tooth Stain • Less Toxic • B-Vitamins
for Added Hemopoietic Activity • Pleasant Flavor • Economical

 The FIRST Hematinic to Contain BOTH CHELATED IRON and CHE-LATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

KELATRATE

LIQUID HEMATINIC

CHELATED IRON-MINERALS and VITAMINS

Comprehensive literature and samples on request.

S. J. TUTAG & CO.

DETROIT 34,

MICHIGAN

blood, mik and Maalox® (magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy must continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation - three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



Specialized Service

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

4N:00

MEDICAL PROPERTY COMPANY

FORTWAYNE INDIANA

Professional Protection Exclusively since 1899

MIAMI OFFICE: H. Maurice McHenry, Rep. 149 Northwest 106th Street, Miami Shores Tel. Plaza 4-2703

APPALACHIAN HALL

ASHEVILLE

Established 1916

NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or encuite

Wm. Ray Griffin Jr., M.D. Robert A. Griffin, M.D. Mark A. Griffin Sr., M.D. Mark A. Griffin Jr., M.D.

For rates and further information write Appalachian Hall, Asheville, N. C.

OBETROI

for medical management of obesity

OBETROL incorporates the desired action of amphetamines with fewer side reactions reported.

MINIMAL SIDE EFFECTS

"In the cooperative patient, OBETROL was markedly beneficial in producing the desirable weight loss with minimal side effects, even in the case of a high percentage of patients with cardiovascular and other chronic ailments which normally make use of other amphetamines undesirable because of side effects" ¹

WEIGHT REDUCTION EFFECTIVE IN DIFFICULT CASES

"With a daily divided dosage of 30 milligrams of OBETROL we were able to obtain appetite depression without nervous restlessness or insomnia . . .

EFFECTIVE WHERE OTHER AMPHETAMINES FAIL

Twenty six patients who previously had been unable to use other amphetamines in any dosage sufficient to maintain the anorectic effect, responded favorably on this medication. 1.3

Contraindications: OBETROL is relatively contraindicated in hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases, anxiety and hyperexcitability. Habituation may occur with prolonged use. As in the case of all ampheta-mines, caution should be used in treating patients with these conditions.

Each OBETROL-10 tablet contains

i Obbi Robio indici comunis.	
Methamphetamine Saccharate	2.5 mgm.
Methamphetamine Hydrochloride	.2.5 mgm.
Amphetamine Sulfate	.2.5 mgm.
Dextroamphetamine Sulfate	2.5 mgm.
(ORETROI - 20 tablate contain twice this notance)	`

Pat. # 2748052.

OBETROL PHARMACEUTICALS

382 Schenck Avenue, Brooklyn 7, N.Y.

¹ Simon. F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, 12:32-37, Jan. 1961.

² Plotz, M.: Modern Management of Obesity, J.A.M.A. 170:1513-1515 (July 25) 1959.

³ Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.

REQUEST SAMPLES AND LITERATURE →

	ARMACEUTICALS Avenue • Brooklyn 7, N. Y.
Or	
Address	
City	State



is dispensed to his patient.

Rx Tablets Quinidine Sulfate Natural
0.2 Gram (or 3 grains)
Davies, Rose

Clinical samples sent to physicians on request

Davies, Rose & Company, Limited

Boston 18, Mass.

CONVENTION PRESS

218 W. CHURCH ST.

JACKSONVILLE, FLORIDA

QUALITY
BOOK PRINTING
PUBLICATIONS
BROCHURES

W HATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine quality work—and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office
JACKSONVILLE

4539 Beach Blvd. Telephone FL 9-2191

ORLANDO

1511 Sligh Blvd. Telephone GA 5-3537



For comprehensive control of the whole pain complex...

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component — chlor-mezanone — 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the whole pain complex — with unsurpassed tolerance.

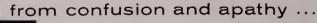
Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily. Reactions to Trancogesic have been minor – gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contrainindicated in persons known or suspected to have an idiosyncrasy to aspirin.

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

TRANCOGESIC*
CHLORMEZANONE with ASPIRIN



1777M



... to Clarity and Interest

Cerebro-Nicin**

CAPSULES

A safe effective cerebral stimulant and vasodilator for your forgetful aging patient. On Cerebro-Nicin therapy, your patient shows improvement in social activity and relationships, and greater concern with personal appearance.

FORMULA:

PTZ (Pentamethylene

Tetrazole)	.100 mg
Nicotinic Acid	.100 mg
Niacinamide	. 5 mg
Vitamin C	.100 mg
Thiamine HCl	. 25 mg
Riboflavin	. 2 mg
Pyridoxine	. 3 mg
1-Glutamic Acid	. 50 mg
	11

INDICATIONS: Apathy, dizzy spells, mild behavior disorders, mental confusion, functional memory defects.

AVERAGE DOSE: One capsule three times daily.

AVAILABLE: Bottles of 100 and 500 capsules.

CAUTION: Most persons experience a flushing and tingling sensation after taking a higher potency niacincontaining compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause for discontinuance of the drug if the patient is forewarned to expect the reaction.

WARNING: Contraindicated in the presence of epilepsy.

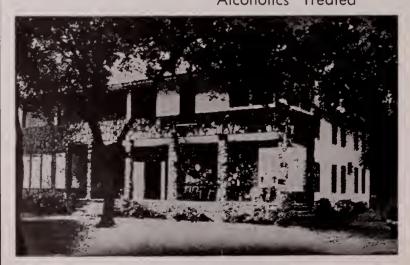


Write for samples and literature...

THE BROWN PHARMACEUTICAL COMPANY
2500 West Sixth Street, Los Angeles 57, California

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders and Invalids Alcoholics Treated



5226 Nichol St. Telephone 61-4191

DON SAVAGE
Owner and Manager

Aged adjudged cases will be accepted on either permanent or temporary basis.

Safety against fire — by Automatic Fire Sprinkling System.

Cyclone fence enclosure for recreation facilities, seventy-five by eighty-five feet.

ACCREDITED
HOSPITAL FOR
NEUROLOGICAL
PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

P. O. Box 10368 Tampa 9, Florida

there is nothing 'new' about Thorazine

5KP 25

chlorpromazine

In the nine years since it became available to American physicians, Thorazine (chlor-promazine, SK&F) has been more widely used, more thoroughly investigated and more extensively documented than any other agent of its type.

Its actions, effects—and side effects—are well known throughout the medical profession. Its efficacy has been clearly demonstrated. And when properly used, its advantages far outweigh any possible disadvantages.

This is why there is nothing "new" about Thorazine (chlorpromazine, SK&F). This is why it remains the first choice in many conditions—and the standard against which other agents are inevitably compared.

This is why it is one of the fundamental drugs in medicine.

SMITH KLINE & FRENCH LABORATORIES, PHILADELPHIA



A special margarine for the atherosclerosis diet

The latest report* in the JAMA on atherosclerosis diets states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

Since this report recognizes table spreads as an important source of dietary fat, we believe that it is in your professional interest to know about the fatty-acid composition of Mrs. Filbert's Corn Oil Margarine.

Mrs. Filbert's Corn Oil Margarine is a special margarine** made from 100% corn oil, over 50% of which retains its liquid characteristics.

Because of its high linoleic content, its ratio of polyunsaturates to saturates is about 1.7 to 1... and equals the highest level available today in *any* corn oil margarine.

Of the total fatty acid content, 28% is cis-cis linoleic acid.

Moreover, when you recommend Mrs. Filbert's Corn Oil Margarine, your patient is assured of receiving unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).

**AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



Made from 100% corn oil with liquid corn oil as its major ingredient

For additional information-including detailed listings of component characteristics-please write to us.

J. H. FILBERT, Inc.

BALTIMORE 29, MARYLAND

why does 150 mg.



do more than 250 mg.



of other tetracyclines?

Because it has up to 31/2 times the in vitro antibacterial activity1...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained in vivo activity with as much as 2 days' extra activity.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. Side Effects typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCl. Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative in vitro Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. Amer. J. Med. Sci. 243:296 (Mar.) 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York





compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.



The distinctive PREMIERE suite



By Hamilton

Smartly styled and finished entirely in lifetime m terials. Wood-grained Formica in gray or crear satin-finish stainless steel and bright chrome crear a contemporary, fully Professional atmosphere — an the Premiere will keep its dignified look for a lifetim Five essential pieces in the suite; table, instrume cabinet, treatment cabinet, waste receptacle and stor. The table is extra large and has a new contoupholstered top to give patients more comfort ar security. Other innovations on the table include a justable chrome legs for leveling or raising the tabl. The usual features of Hide-A-Roll, treatment bas and pull-out step are included.

Versatility is the keynote of the Premiere suite. The upper section of the instrument cabinet can used separately as a wall cabinet and the lower section as a treatment stand. This option allows a great variety of room arrangement according to personal preference and requirements.

See the new Premiere and other Hamilton suites in wood and steel now.

Anderson Surgical Supply Co.

ESTABLISHED 1916

Phone CHerry 1-9589 1616 N. Orange Ave. Orlando Phone 896-3107 556 9th St. S. St. Petersburg Phone 229-8504 Morgan at Platt Tampa Phone 376-8253 729 S.W. 4th Ave. Gainesville



NEW!

Around the clock relief for DISTRESS OF COLDS

SOGLOR TIMESULE

LOR TIMESULE CONTAINS:

- iramine maleate 10 mg.
 drine HCl 65 mg.
 ial form providing prolonged
- or Timesule, actual size

Schematic

drawing of

mesule cell

ing dialysis

nermeable.

coating.



A NEW COMPREHENSIVE RELIEF

- Relief usually starts in minutes—to open nasal passages, stop running nose and eyes, sneezing, wheezing, itching and post-nasal drip
- Relief usually lasts up to 12 hours with a single oral dose
- Gives both upper respiratory decongestion and bronchodilatation to relieve chest discomfort
- With minimal drowsiness, CNS or pressor stimulation

MADE POSSIBLE BY THE NEW TIMESULE RELEASE MECHANISM

Release with the Isoclor Timesule is at a relatively even, constant rate, independent of gastrointestinal motility, pH, or enzymatic activity. Each Timesule pellet is actually a micro dialysis cell, consisting of a drug core with coating of dialyzing membrane of precisely controlled permeability. Approximately 20% of active drugs are released within one hour and 80% in 8 hours. Peaks and valleys of over-release and under-release are minimized for constant, controlled relief with minimum side effects.

DOSE: Adults: One Timesule every 12 hours, or as directed.

WARNING: Use with caution in patients suffering from hypertension, cardiac disease, hyperthyroidism or diabetes. Patients susceptible to the soporific effect of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

Send for Samples and Literature



BELONGS IN EVERY PRACTICE

it's Versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy.

Outstanding record of safety: Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it "belongs in every practice."

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress—and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: Indications: Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. Side Effects: Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. Complete product information available to physicians on request.

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d. SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.



he insomniac



The tense, nervous patient



The heart-disease patient



The surgical patient



rl with dermatosis



Tension headache



The woman in menopause



Anxious depression



enstrual tension



The agitated senile patient



The alcoholic



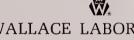
The problem child

the original brand of meprobamate

Miltown



The G.I. patient



WALLACE LABORATORIES Cranbury, N.J.

FLORIDA MEDICAL ASSOCIATION

735 Riverside Ave., P. O. Box 2411 Jacksonville 3, Florida

Officers

WARREN W. QUILLIAN, M.D., President	Coral Gable.
SAMUEL M. DAY, M.D., President-Elect	
H. PHILLIP HAMPTON, M.D., Vice President	Tampa
EUGENE G. PEEK JR., M.D., Speaker of the House	
FRANKLIN J. EVANS, M.D., Vice Speaker	
FLOYD K. HURT, M.D., Secretary-Treasurer	Jacksonville
ROBERT E. ZELLNER, M.D., Immediate Past President	
W. HAROLD PARHAM, Executive Director	Jacksonville

Councils

THOMAS C. KENASTON SR., M.D., Chairman, Council on Allied Professions and Vocations	Cocoa
JERE W. ANNIS, M.D., Chairman, Judicial Council	Lakeland
H. PHILLIP HAMPTON, M.D., Chairman, Council on Legislation and Public Agencies	Татра
BURNS A. DOBBINS JR., M.D., Chairman, Council on Medical Economics	Fort Lauderdale
HUGH A. CARITHERS JR., M.D., Chairman, Council on Medical Education and Hospitals	Jacksonville
CHARLES R. SIAS, M.D., Chairman, Council on Medical Services	Orlando
THAD MOSELEY, M.D., Chairman, Scientific Council	Jacksonville
WALTER C. PAYNE SR., M.D., Chairman, Council on Special Activities	Pensacola
EMMET F. FERGUSON JR., M.D., Chairman, Council on Specialty Medicine	Jacksonville
MASON ROMAINE III, M.D., Chairman, Council on Voluntary Health Agencies	Jacksonville

INDEX TO ADVERTISERS

• Ames Co., Inc	Third Cover	Medical Supply Co	324
Anderson Surgical Supply Co		Obetrol Pharmaceuticals	323
Appalachian Hall		• Parke Davis & Co.	Second Cover, 259
Ballast Point Manor	326	• P. L. Dodge Memorial Hospital	320
Brawner Hospital, Inc	320	• PM of Florida	314
Brown Pharmaceutical Co	318, 326	• A. H. Robins Co.	271, 310a, 311
Burroughs-Wellcome & Co	262, 312	• Roche Laboratories	Back Cover
• Chatham Pharmaceuticals, Inc	305	• William H. Rorer, Inc.	321
• Coca-Cola Co.	330	• Sanborn Co.	313
Convention Press		Saron Pharmacal Corp	314
• Davies-Rose & Co		• W. B. Saunders Co.	269
Dorsey Laboratories	267	Schering 'Corporation	273
Duvall Home	303	• G. D. Searle Company	299
• Endo Laboratories	306	• Smith, Kline & French	327
• J. H. Filbert Inc.	328	• Standard Brands, Inc.	
Geigy Pharmaceuticals	263, 266	Surgical Supply Co	
• Hart Laboratories	309	• Tucker Hospital, Inc.	
Hill Crest Sanitarium	314	• S. J. Tutag & 'Co	
• Charles C. Haskell & Co.	331	• U. S. Vitamin & Pharmaceutical C	
• Lederle Laboratories 268	8, 301, 316, 317, 329		
• Eli Lilly & Co	274	• Bob Wagner X-Ray	
Loma Linda Foods		• Wallace Laboratories 272, 30	
Medical Protective Co	322	• Winthrop Laboratories	260, 270, 307, 325
			Valuma 50/Number 4

neither **tension**, nor **spasm**,
nor **stasis**stays this patient
from his
appointed rounds



DECHOLIN-BB

. especially when UPPER G.I. COMPLAINTS have biliary implications

for nervous tension

BUTABARBUTAL SOUM

Each Tablet Contains:

for smooth-muscle spasm

BELLADONNA EXTRAGI

for biliary/intestinal stasis

DETYDROGUOLIC ACID

Average adult dose: 1 or, if necessary, 2 tablets three times daily. Precautions: Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction; caution drivers against possible drowsiness. Side effects: Dehydrocholic acid may cause transitory diarrhea; belladonna may cause blurred vision and dry mouth. Contraindications: Biliary tract obstruction, acute hepatitis, glaucoma, prostatic hypertrophy. Available: DECHOLIN-BB, bottles of 100 tablets. Also: DECHOLIN® with Belladonna (dehydrocholic acid, 250 mg.; belladonna extract, 10 mg.) and DECHOLIN® (dehydrocholic acid, 250 mg.), bottles of 100 and 500 tablets.



Library
New York Academy of Medicine
2 East 103rd St
New York 29 N Y J 12-63





Dosage: Oral - Usual adult dose in mild to moderate anxiety and tension is 5 or 10 mg, 3 or 4 times daily; in severe anxiety and tension, 20 or 25 mg, 3 or 4 times daily. Side Effects: Oral - Drowsiness and ataxia, usually dose-related, have been reported in some patients -- particularly the elderly and debilitated. Paradoxical reactions, i.e., excitement, stimulation, elevation of affect and acute rage, have been reported in psychiatric patients; these reactions may be secondary to relief of anxiety and should be watched for in the early stages of therapy. Other side effects, usually dose-related, have included isolated instances of minor skin rashes, minor menstrual irregularities, nausea, constipation, increased and decreased libido. Precautions: Oral-In elderly, debilitated patients, limit dosage to smallest effective amount to preclude development of ataxia or oversedation (not more than 10 mg per day initially, to be increased gradually as needed and tolerated). Until the correct maintenance dosage is established, patients receiving this agent should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Caution patients about possible combined effects with alcohol. Caution should be exercised in administering Librium (chlordiazepoxide HCI) to addictionprone individuals. Careful consideration should be given to the pharmacology of any agents to be employed concomitantly-particularly the MAO inhibitors and phenothiazines. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests may be advisable in protracted treatment. Caution should be exercised in prescribing any therapeutic agent to pregnant patients.

- November, 1963

The JOURNAL

of the Florida Medical Association

MARCOLLINE AND DIAMETER NIV.

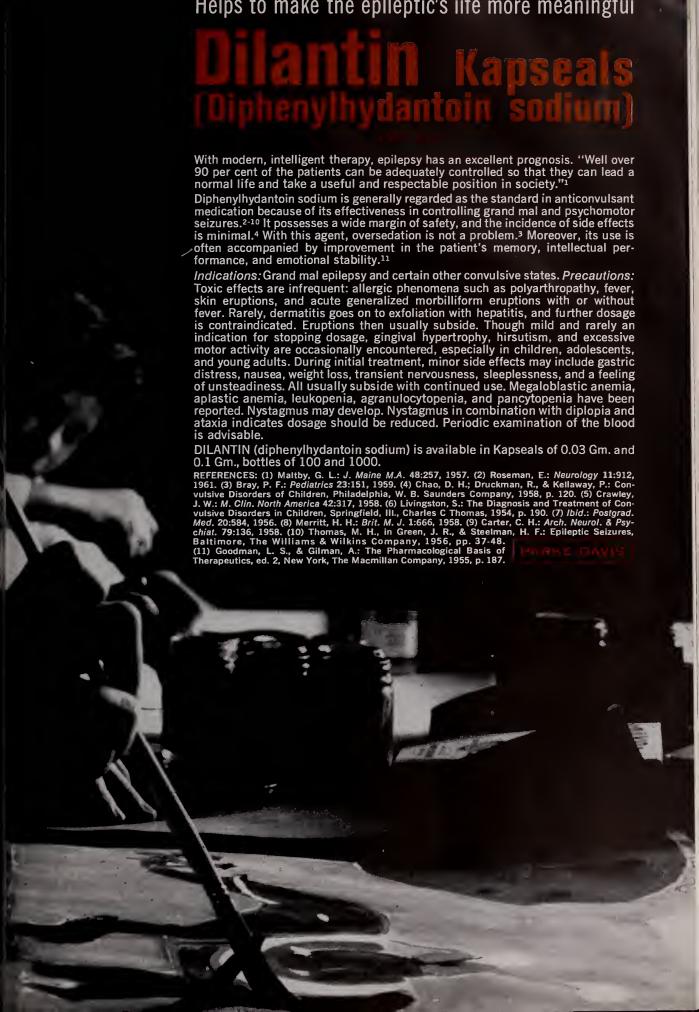
AMAPUT LASTIC REACTIONS TO PENICILLIN

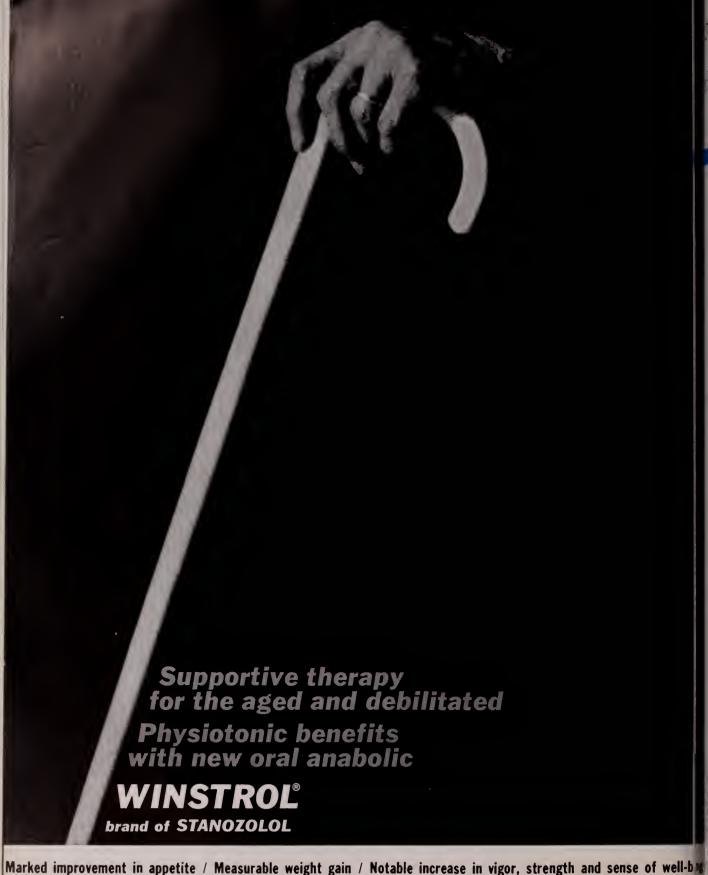
ATSECTION IN DEPARTMENT BIOCHEMISTRY

PATERIN COLO SYNDEOME









New anabolic Winstrol combines highest potency* with outstanding tolerance in an economical oral tablet. Employed adjunctively, its physiotonic benefits are evident in the management of a variety of patients: the geriatric; the post-operative; the weak; the debilitated with chronic or malignant disorders. Winstrol reverses tissue depleting processes, restores a positive metabolic balance, rebuilds body tissue while it builds strength, builds confidence and restores a sense of well-being.

Usual Adult Dose: I tablet t.i.d. Before prescribing, consult literature for tional dosage information, possible side effects and contraindications. Supplied: 2 mg. tablets. Bottles of 100.

With Winstrol, patients look better...feel strongerbecause they are stronger!

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

The JOURNAL of the Florida Medical Association

te 1 torioù 14teoreur 16330erurro.

Volume 50, Number 5, November 1963

THIS ISSUE

Hyperinsulinism, H. J. Roberts, M.D. 355

The Syndrome of Narcolepsy and Diabetogenic (Functional)

Research in the Department of Biochemistry, University of Florida, Frank W. Putnam, Ph.D.

Fatal Anaphylactic Reaction Due to Penicillin, Arthur F. Schiff, M.D.

ГНАД	MOSELEY,	M.D.
	Editor	

SHALER RICHARDSON, M.D. Editor Emeritus

Assistant Editors

CHARLES K. DONEGAN, M.D. FRANZ H. STEWART, M.D. JOHN M. PACKARD. M.D.

THOMAS R. JARVIS
Managing Editor

Louise Rader
Assistant
Managing Editor

EDITH B. HILL Editorial Consultant

Published monthly at Jacksonville. Florida. Price \$7.00 a year: single numbers, 70 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville, Fla., 32203. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103. Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Editorials

Articles

Thanksgiving, Jere W. Annis, M.D.	376
Narcolepsy and Hypoglycemia, John M. Packard, M.D.	376
The Battered Child Syndrome, Ben J. Sheppard, M.D., L.L.B.	377

Features

President's Page	374
Coordinated Scientific Program, Richard C. Dever, M.D.	378
Association News	379
Letter to the Editor	381
News	382
Meetings	384
Classified	388
Florida Medical Association Officers and Council Chairmen	414

This Journal is not responsible for the opinions and statements of its contributors. Owned and published by the Florida Medical Association.

cut Rx writing by 2/3 in colds, flu or grippe

NAME

ADDRESS

R

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound...to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC 'EMPRAZIL-C'TABLETS

Each tablet contains:

*Warning-may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. Caution:

While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcy-clizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. Supplied: Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO (U.S.A.) INC.

Tuckahoe, N. Y.

"They keep saying I'm sloppy!"



Nicozol® helps you restore your geriatric patients' interest in themselves

NICOZOL therapy can help you brighten the outlook of your aging patients who tend towards (1) untidiness, (2) irritability, (3) incompatibility, (4) lack of interest, and (5) loss of memory or alertness.

The NICOZOL formula helps improve mental acuity, increase the supply and use of oxygen in the brain, improve peripheral circulation—without excitation, depression, or other untoward effects.

NICOZOL can help you keep your aging patients actively alert and at ease with themselves, their families, and others.

Supplied: NICOZOL tablets (and capsules) in bottles of 100 and 1000. NICOZOL elixir in pints and gallons.

Precautions: May produce overstimulation in high doses. Discontinue if muscular twitchings or clonic convulsions occur. The flush produced in sensitive individuals is transient and harmless.

Average Dose: 1 to 2 tablets (or capsules) 3 times a day. 1 teaspoonful elixir 3 times a day.

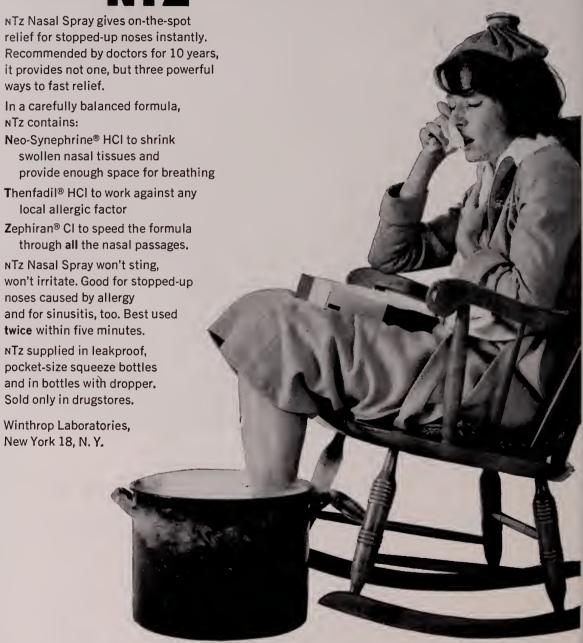
HART

Division of A. J. Parker Co.
LABORATORIES
Bryn Mawr, Pa., Winston-Salem, N.C.

NICOZOL

Alcohol....

Colds haven't changed—but relief has with NTZ®NASAL SPRAY





NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

THE FIRST OBJECTIVE IN RELIEVING SINUS HEADACHE IS A PATENT PATIENT

The second, of course, is relieving the headache. Headache gone, sinus clear. The patent patient may not know it, but his sinus headache disappeared because in addition to analgesia, the tablet he took also relieved congestion. That's how Ursinus works.

Each Inlay-Tab® contains the completely soluble analgesic Calurin® (brand of calcium carbaspirin) equivalent to 300 mg. aspirin, plus the time-tested decongestant Triaminic® 50 mg. (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.). Use with caution in presence of hypertension, heart disease, diabetes, or thyrotoxicosis. If drowsiness occurs, patient should not engage in activities requiring maximum alertness. Usual dose is one Inlay-Tab four times a day. HEADACHE GONE, SINUS CLEAR.

HAVE YOU TRIED URSINUS * YET?

DORSEY LABORATORIES · a division of The Wander Company · LINCOLN, NEBRASKA

"What type of drug is both a tranquilizer and a muscle relaxant?"

"a tranquilaxant."

TRANCOPAL chlormezanone is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone-Winthrop) "is effective in the symptomatic treatment of anxiety." Its tranquilizing properties are similar to those of other mild tranquilizers. Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of this true "tranquilaxant" is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlor-mezanone-Winthrop), such as occasional drowsiness,

dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets (green colored, scored). 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Reference: 1. A.M.A. Council on Drugs: J.A.M.A. <u>183</u>:469 (Feb. 9) 1963.

Winthrop
WINTHROP LABORATORIES

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin, brand of dipyridamole

See next 3 pages

Study 1.

Griep, A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:

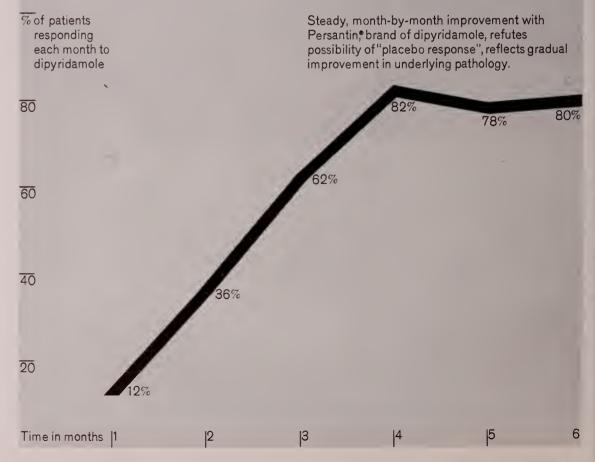
A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin, brand of dipyridamole, 25 mg. t.i.d. or q.i.d., was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis.

Persantin® brand of dipyridamole

"..long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients...

"relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"



Study 2.

Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472,1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin, brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

Geigy

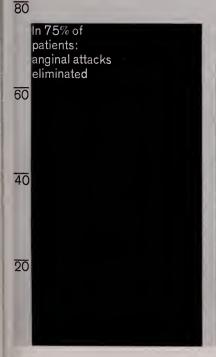
After 3 months, 32 of 40 patients showed:

"..reduction or abolition of acute anginal attacks...

"complete or almost complete disappearance of ECG abnormalities...

"marked increase"in walking distance without anginal symptoms

% of patients







Persantin® brand of dipyridamole

How long-term therapy provides clinical benefits reported on previous pages

1. By increasing energy yield

of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).¹⁻⁵

2. By improving collateral coronary circulation.

Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.⁶⁻⁹

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:

Tablets of 25 mg., bottles of 100 and 1000. Under license from Boehringer Ingelheim G.m.b.H.

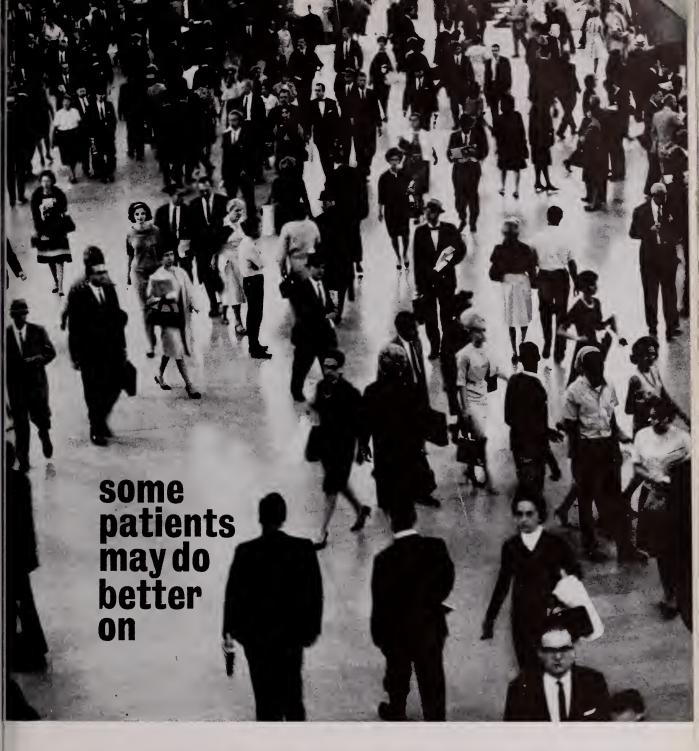
Prescribing summary: Persantin, brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.



Geigy Pharmaceuticals Division of Geigy Chemical Corporation Ardsley, New York, Distributors

DF-2290



ACHROCIDIN

TETRACYCLINE HCI-ANTIHISTAMINE-ANALGESIC COMPOUND

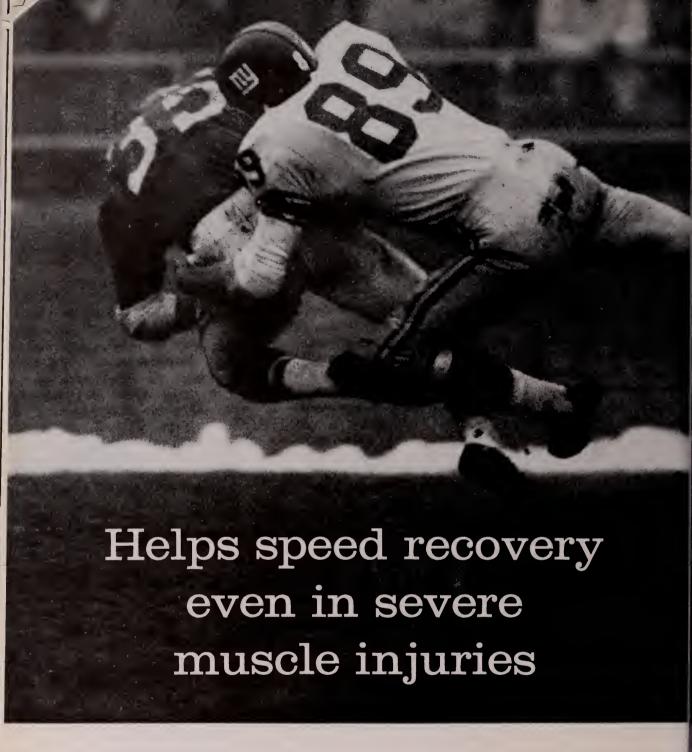
Each Tablet contains: ACHROMYCIN® Tetracycline HCI . . 125 mg. Acetophenetidin (Phenacetin) 120 mg.

Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets four times daily.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle





Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. (Clinical Medicine, March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely. For severe athletic strains or everyday sprains,

you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

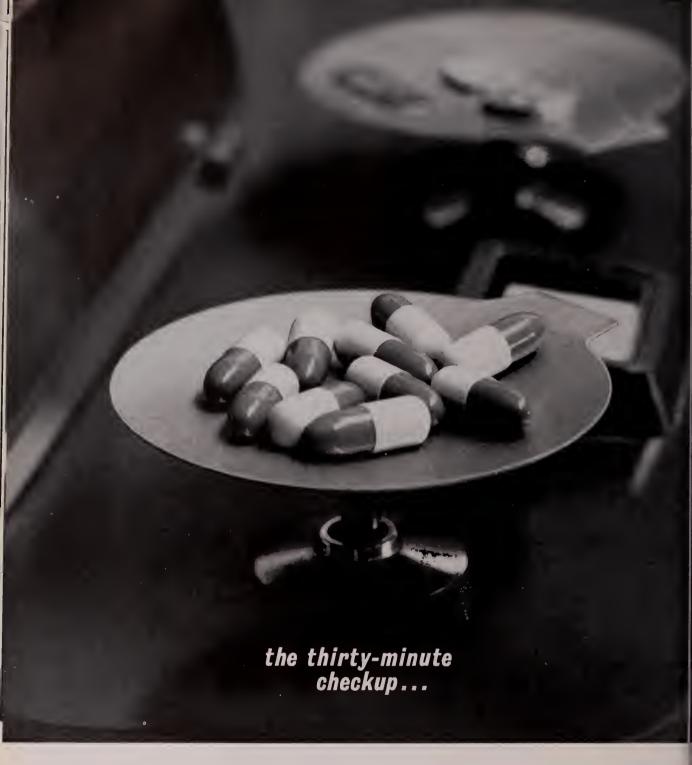


Wallace Laboratories, Cranbury, New Jersey

blood, milk and Maalox® (magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy must continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation - three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)





Empty capsules are filled by the finest precision machinery available . . . but no machine is perfect. That's why all Lilly Pulvules® (filled capsules) are given the "thirty-minute checkup" to be certain that uniformity is maintained. At least once every thirty minutes ten filled capsules are taken from

each machine and carefully weighed on a prescription balance. In addition, the checks are double-checked at least four times each day . . . another of the many stringent controls which assure you that the Lilly products you prescribe provide quality that merits the full measure of your confidence.

The JOURNAL

of the Florida Medical Association

The Syndrome of Narcolepsy and Diabetogenic (Functional) Hyperinsulinism

Observations on 190 Patients, with Emphasis upon Its Relationship to Obesity, Diabetes Mellitus and Cerebral Dysrhythmias

H. J. Roberts, M.D. West Palm Beach

"In a word, physiologists and physicians must seek to reduce vital properties to physico-chemical properties, and not physico-chemical properties to vital properties."

Claude Bernard¹

In recent years, I have observed 190 patients with a syndrome that is of practical importance to every physician.²⁻⁵ It consists of true narcolepsy and recurrent hypoglycemia due to "functional" hyperinsulinism, with or without associated diabetes mellitus and other complications. The latter include obesity, vascular headaches, cerebral dysrhythmias, peripheral neuropathies, angina pectoris, cardiac arrhythmias, "refractory" peptic ulcer, and alcoholism. These sequelae are believed to be chiefly the consequences of repeated hypoglycemic stress.

By way of further introduction, the following four basic tenets are set forth:

- (1) This syndrome effectively inter-relates a number of important disorders that are frequently encountered in medical practice.
- (2) A genetically determined abnormality that leads to excessive insulinogenesis and influences hypothalamic function appears to be operative. Either sex may be affected. The supporting evidence for this hypothesis stems from the present clinical observations, many anatomic and physiologic considerations, various manifestations of disease including the so-called "third ventricle syn-

drome," and a number of experimental studies which bear upon the function of the hypothalamus, notably those dealing with sleep, satiety, and goldthioglucose-induced lesions. 6-8

- (3) It bears a close relationship to the genesis, recognition and management of both obesity and diabetes mellitus with its complications.
- (4) Correct diagnosis requires a careful history and a constant awareness of this entity.

There are many important reasons for correctly diagnosing this syndrome. They include the following:

- (1) It is a common condition.
- (2) One component of the syndrome or its complications can alert the clinician to the presence of the others and also to previously unsuspected diabetes mellitus.
- (3) A number of vague or hazardous misdiagnoses currently in vogue will be averted by such insight. These include metabolic insufficiency, euthyroid hypometabolism, psychosomatic obesity, the night-eating syndrome, the Kleine-Levin syndrome, hypothyroidism, adrenal insufficiency, psychoneurosis, senility, "obesity as a depressive equivalent," the Pickwickian syndrome, the fatigue syndrome, hypokinetic disease, low blood pressure, chronic nervous exhaustion, premature menopause, and "laziness," especially in the case of children and Negro patients. Similarly, correct diagnosis will avert much of the current misuse

Read before the Florida Medical Association, Eighty-Ninth Annual Meeting, Hollywood, May 16, 1963.

of the term "psychophysiologic phenomenon" as a wastebasket diagnosis.

- (4) Certain potential complications can be prevented thereby. These include accidents while driving, the activation or aggravation of peptic ulcer, the needless administration of thyroid substance or cortisone-like steroids, and the precipitation of angina pectoris, cardiac arrhythmias and migraine. For example, the statistics of the National Safety Council based upon all traffic accidents, exclusive of those related to drinking, reported from 13 states during 1960 indicate that the condition of the driver was "asleep" and "fatigue" in 36 per cent and 18 per cent, respectively; 12 in the case of fatal accidents, the "asleep" figure rose to 47 per cent.
- (5) Effective therapy is readily and inexpensively available for each component. On the other

- hard, treatment will generally be suboptimal or ineffective if management is not sufficiently panoramic. For example, the failure to recognize the role of recurrent hypoglycemia in perpetuating obesity is a recurrent shortcoming of most weight-reducing programs.
- (6) Effective prophylaxis also can be instituted. In this regard, particular reference is directed to the nonobese "early" diabetic and to patients who have angina pectoris, cardiac arrhythmias, vascular headaches and peptic ulcer.
- (7) There are important familial ramifications, especially as related to the phenomenon of "anticipation," or "antecedence," in narcolepsy and in diabetes mellitus.¹³ Accordingly, it will be possible to uncover many instances of the syndrome in children when a parent is so afflicted—and vice versa.

Table 1

	Gro	UP I(NO)	Grou	P II (NN)	Grou	PIII (DO)	Grot	CP IV (DN)	1	TOTALS
PATIENTS		49		29		78		34		190
Females	30	(61.2%)	17	(58.6%)		(60.2%)	27	(79.4%)	121	(63.2%)
Males	19	(38.8%)	12	(41.4%)	31	(39.8%)	7	(20.6%)	69	(36.8%)
White	44	(89.8%)	27	(93.1%)	67	(85.9%)		(97.1%)	171	(90.0%)
Negro	5	(10.2%)	2	(6.9%)	11	(14.1%)	1	(2.9%)	19	(10.0%)
Average age										
(years)		45.9		44.8		51.0		45.3		46.7
Over 60 years	4	(8.2%)	0		23	(29.5%)	7	(20.6%)	34	(17.9%)
F.H. narcolepsy	31	(63.3%)	18	(62.1%)	51	(65.4%)	21	(61.8%)	121	(63.2%)
F.H. diabetes		(24.5%)		(27.6%)		(43.5%)		(52.9%)		(37.8%)
Cataplexy		(48.9%)		(37.9%)		(42.2%)		(50.0%)		(44.8%)
Hypnagogic	- '	(10.7/6)	• •	(07.276)		(,2,2,0)		(00.0)		(, ,,,,,,,
hallucinations	30	(61.2%)	17	(58.6%)	30	(50.0%)	1.8	(52.9%)	104	(54.7%)
Sleep paralysis		(44.9%)		(34.5%)		(35.9%)		(38.2%)		(38.4%)
Complete narcolept		(44.7/6)	10	(34.370)	20	(33.9/6)	10	(30.2 / €)	75	(30.4 /0)
tetrad		(36.7%)	8	(27.6%)	23	(29.5%)	Q	(26.5%)	26	(13.7%)
Three of the tetra				(10.3%)		(10.3%)		(20.6%)		(13.7%)
Previous thyroid	u o	(10.5%)	3	(10.570)	0	(10.576)	′	(20.0 /6)	20	(13.777)
therapy	12	(24.5%)	2	(10.3%)	1.4	(17.9%)	2	(8.8%)	2.7	(16.8%)
Vascular headaches								(67.9%)		(65.8%)
		(65.3%)		(75.9%)		(61.5%)				
Recurrent edema		(48.9%)		(41.4%)		(53.8%)		(47.1%)		(49.5%)
Males		(6.1%)		(3.4%)		(5.1%)	0	(0.00()		(4.2%)
Menopause		(38.8%)		(27.6%)		(43.5%)		(8.8%)		(38.9%)
Spontaneous		(14.3%)		(13.8%)		(28.2%)		(17.6%)		(20.5%)
Iatrogenic		(24.5%)		(13.8%)		(15.4%)		(20.6%)		(18.4%)
Neuropathy	18	(36.7%)	5	(17.2%)	44	(56.4%)	11	(32.4%)	78	(41.1%)
Leg cramps —								-4		
"restless legs" 9 o	of 12	(75.0%)		(66.2%)		(66.6%)		(90.0%)		(75.0%)
Angina pectoris	19	(38.8%)	6	(20.7%)	34	(43.6%)	10	(3.4%)	69	(36.3%)
Cardiac										
arrhythmias	23	(46.9%)	6	(20.7%)	30	(38.7%)	16	(47.1%)	75	(39.5%)
Psychiatric										
disability	16	(32.7%)	6	(20.7%)	16	(20.5%)	18	(52.9%)	54	(28.4%)
Alcoholism	3	(6.1%)	1	(3.4%)	13	(16.7%)	3	(8.8%)		(10.5%)
Peptic Ulcer	8	(16.3%)	4	(13.8%)	7	(8.9%)	5	(14.7%c)	24	(12.6%)
Patients studied										
by EEG	13	(26.5%)	6	(20.7%)	27	(34.3%)	16	(47.1%)	62	(32.6%)
Low-voltage fast										
activity 7	of 13	(53.1%)	3 of 6	(50.0%)	12 of 27	(44.4%)	5 of 16	(31.2%)	27 of 62	(43.5%)
High-voltage		(/-/		(,-,						•
	of 13	(61.5%)	5 of 6	(83.3%)	12 of 27	(44.4%)	7 of 16	(43.8%)	32 of 62	(51.6%)
High-voltage		(01.07()	0 0. 0	(00.070)		(, , , , , ,		(, . ,		, , ,
paroxysmal										
	of 13	(15.4%)	3 of 6	(50.0%)	8 of 27	(29.6%)	3 of 16	(18.7%)	16 of 62	(25.8%)
14-and-6/sec.,	01 10	(20.1/0)	0 0.0	(20.0/0)	0 0. 27	(= > / ()	0.01.10	, , _ ,		, , , , ,
14/sec., or										
	of 13	(0)	2 of 6	(33.3%)	4 of 27	(15.0%)	3 of 16	(13.7%)	9 of 62	(12.9%)
0/3001	VI 10	(3)	2010	(00.070)	7 (1 5)	(20.070)	00.20	(-011/1)		, . ,

Clinical Data

A total of 190 patients with both true narcolepsy and recurrent hypoglycemia have been personally attended. The pertinent data are summarized in table 1.

Concerning sex distribution, there were 121 females (63.2 per cent) and 69 males (36.8 per cent). This contrasts with the widespread belief that narcolepsy is predominantly a disease of males.

The age range was 13 to 76 years, the average age being 46.7 years. A further breakdown of average ages according to the presence or absence of diabetes mellitus and obesity is as follows:

Nondiabetic obese (NO) group (49 patients)—45,9 years

Nondiabetic nonobese (NN) group (29 patients)—44.8 years

Diabetic obese (DO) group (78 patients)
—51 years

Diabetic nonobese (DN) group (34 patients)—45.3 years

It should be pointed out that most of the 34 patients (17.9 per cent) over the age of 60 years experienced the syndrome virtually their entire adult lives, but it had remained undiagnosed in spite of considerable doctoring. Moreover, several of the patients who were initially seen in their early or middle teens gave narcoleptic symptoms dating back to their first decade. In the six year old son of a diabetic woman (case DO-25) the syndrome appears to be developing, but he is not included in this series.

There were 171 white patients (90 per cent) in this series. The finding of the complete narcoleptic complex among 19 Negroes (10 per cent), however, in a predominantly non-Negro consultation practice strongly suggests that narcolepsy is very common in the Negro race. This observation is also supported by the striking low-voltage or "sleep" patterns in many of their preglucose electroencephalograms (vide infra), and by a continuing study of the problem among service Negro patients.

Most of these patients (127 or 66.8 per cent) were obese by the criteria used, namely, 10 pounds or more above the upper limits of their desirable weight. In large measure, their obesity is believed to be the aftermath of (1) the increased appetite generated by recurrent hypoglycemia, and (2) reduced caloric expenditure as a result of narcoleptic drowsiness and prolonged sleep.

The criteria for the diagnosis of narcolepsy were strict. The following features were specifically sought out:

- (1) The hallmark of irresistible drowsiness in the absence of physical fatigue, after an adequate night's sleep, and with proper motivation (for example, while driving, during dental work, or in the course of a medical interview) was present in every patient.
- (2), (3), (4) Hypnagogic hallucinations, cataplexy, and sleep paralysis were admitted by 104 patients (54.7 per cent), 85 patients (44.8 per cent), and 73 patients (38.4 per cent), respectively.
- (5) A definite or highly suggestive family history of narcolepsy could be obtained from 121 patients (63.2 per cent). Whenever possible, the records of other physicians were reviewed when a diagnosis such as hypothyroidism had been made in close relatives.
- (6) Electroencephalographic evidence of marked drowsiness or sleep was found in 49 (79 per cent) of 62 patients who underwent such study. It should be pointed out that owing to unavoidable technical delays, a corrective diet and analeptic therapy had been instituted prior to electroencephalography for periods ranging from two weeks to six months in those patients who failed to fall asleep.
- (7) A dramatic response to the trial of an analeptic agent in relatively small doses—notably methylphenidate hydrochloride (Ritalin)—occurred in the majority of these patients when it was given either orally or parenterally. At least six of these seven diagnostic criteria—or five out of the six when electroencephalograms or a reliable family history could not be obtained—were present in 52 patients (27.4 per cent).

It is of interest that several narcoleptic patients first presented themselves for "possible encephalitis" during the recent well publicized endemic of this infection in Florida. It would appear that a modification of the classic admonition pertaining to asthma, "all that wheezes is not asthma," can be aptly directed to narcolepsy—that is, "all that sleeps is not encephalitis."

Recurrent hypoglycemia was attributed to "functional nondiabetic hyperinsulinism" in 78 patients (41.1 per cent). The criteria for this diagnosis included the occurrence of typical hypoglycemic symptoms several hours after eating, the prompt response of these features to the ingestion of food or sugar, and the absence of diag-

nostic hyperglycemia in both morning and afternoon glucose tolerance tests.

Recurrent hypoglycemia was associated with diabetes mellitus in 112 patients (58.9 per cent). Diabetes mellitus had been previously known or suspected in only 24 patients. Fasting hyperglycemia was recorded in 46 patients. Abnormal morning glucose tolerance was noted in 56 patients, and also was present in those patients in whom verification of the diagnosis was sought when the fasting blood glucose concentrations did not exceed 140 mg. per hundred cubic centimeters (Folin-Wu). It is of great import that unequivocally impaired *afternoon* glucose tolerance was present in 10 additional patients whose morning glucose tolerance tests were "nondiabetic."

A family history of diabetes mellitus was obtained in 72 patients (37.8 per cent). The fact that 20 of these patients were in the group classified as having "functional nondiabetic hyperinsulinism" is important since many will undoubtedly prove to be diabetic in the course of more prolonged observation.

No patient fulfilled the standard criteria for "organic" hyperinsulinism due to an islet-cell tumor. Similarly, the diagnoses of adrenocortical hyperfunction and pheochromocytoma were specifically excluded by appropriate studies whenever these possibilities were raised.

Associated Features and Complications

The incidence of classic migraine and so-called histaminic cephalgia was noteworthy in this group of patients, being present in 125 (65.8 per cent). In the majority, hypoglycemia was unequivocally shown to be capable of precipitating and reproducing the attacks of vascular headache (fig. 1). I remain unconvinced that: (1) these types of headache are "allergic" in the classic immunologic sense; 14 (2) histamine and serotonin metabolism is pathologically deranged in such patients; and (3) treatment with potent antiserotonin drugs or by means of "histamine desensitization" is either rational or effective. (I have previously devoted two years of clinical research to the pharmacologic effects of histamine and cholinergic agents in asthmatic patients.) The inability of these patients to tolerate chocolate is largely explainable as the consequence of reactive hypoglycemia that can be almost predictably precipitated by the ingestion of the excessive sugar contained therein.

Recurrent edema ("idiopathic" edema) was a prominent feature in 94 patients (49.5 per cent),

including eight males. There is evidence that such edema may be related to the excessive ingestion of carbohydrate because of the ensuing inhibition of sodium excretion and water retention.15 In fact, the edema was dramatically reproduced in a number of patients either during glucose tolerance tests or within one day following glucose loading. It is of related interest that 3 young obese women with severe recurrent hypoglycemia in this series appear to confirm the reversed diurnal excretory rhythm of water, creatinine and electrolytes reported by Ezrin and his colleagues¹⁶ in a 39 year old woman with recurrent edema, obesity and somnolence. Dramatic improvement was forthcoming in the latter patient after the administration of synthetic oxytocin.

Troublesome peripheral neuropathies were prominent complaints in 78 patients (41.1 per cent), both with and without demonstrable impairment of glucose tolerance. Their symptoms were most often characterized as intense burning and lancinating pains, especially in the lower extremities.

Severe leg cramps, "restless legs," or both—generally during the night—also constituted a common complaint. These symptoms were promptly admitted by 30 (75 per cent) of the 40 patients who were queried, since they were not specifically sought out until late in this study. A corrective diet effected dramatic improvement in virtually every patient, even after numerous drugs, for example, quinine and diphenhydramine, had been unsuccessfully tried.

The menopause was present in 74 patients (38.9 per cent). It had been surgically induced in 35 patients (18.4 per cent). On the other hand, many young women in this series whose menses were normal had been repeatedly diagnosed as having an "early change" because of recurrent sweats and "hot flushes," which were actually manifestations of the episodic hypoglycemia. The associated extensive sweat retention and acneiform eruption present in several responded promptly to a corrective diet, even after previous dermatologic consultation and management had proved ineffective.

Classic angina pectoris and paroxysmal tachycardia were present in 69 patients (36.3 per cent) and 75 patients (39.5 per cent), respectively. In many instances, these features had persisted in spite of standard therapeutic measures until the contributory recurrent hypoglycemia was appreciated and corrected. The occurrence of these symptoms three hours or longer after eating or during the early hours of the morning should always suggest a triggering hypoglycemic mechanism (fig. 1). These principles were clearly cited by Harrison and Finks¹⁷ two decades ago, but have been virtually forgotten by most cardiologists.

Significant psychiatric features, notably anxiety and depression, were present in 54 patients (28.4 per cent). In many, such disability could be specifically correlated with the attacks of hypoglycemia. The importance of this association was repeatedly underscored by (1) the failure of these patients to exhibit clinical improvement on prolonged formal psychiatric therapy, tranquilizing medication in high dosages, and electroshock treatment, and (2) their gratifying response to a regimen essentially centered about a corrective diet and an analeptic agent. On the basis of my observations, I am convinced that narcolepsy is not primarily a psychiatric disorder in the overwhelming majority of patients so afflicted, but is rather a nonspecific symptomatic expression of deranged cerebral function.

Unnecessary thyroid substance was being taken or had been taken by 32 patients (16.8 per cent). Of this group, permanent iatrogenic hypothyroidism had probably developed in four.

A persistently active "refractory" duodenal ulcer was a major feature in 24 patients (12.6 per cent). The stimulation of excessive gastric hydrochloric acid following insulin-induced hypoglycemia¹⁸ or hypothalamic stimulation¹⁹ is well known. The antihypoglycemic nature of most standard ulcer diets is also pertinent.

Twenty patients (10.5 per cent) were drinking alcohol to excess when first seen, but primarily and unknowingly for the amelioration of disabling hypoglycemic symptoms, especially tremors. Derangement of liver function was absent or minimal in those with impaired glucose tolerance. With but four exceptions, all could be totally weaned off alcohol by a corrective diet and supportive measures.

It is of considerable interest that pregnancy occurred in two patients (cases DO-5 and DO-70) after a diagnosis of the syndrome of narcolepsy and recurrent hypoglycemia had been made. Impaired glucose tolerance was present prior to and after gestation, respectively. Their clinical course during gestation was characterized by (1) severe "morning sickness" and marked gain in weight during the first half of pregnancy, (2) a complete

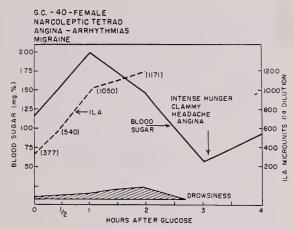


Fig. 1. — Correlative sequence of simultaneous morning glucose tolerance testing and insulin-like activity assays in a narcoleptic white woman with migraine, angina pectoris and impaired glucose tolerance.

remission of hypoglycemic and narcoleptic symptoms during the third trimester, (3) large babies, and (4) adequate lactation during the postpartum period. On the basis of both a retrospective study of other patients in this series and general obstetrical experience, the syndrome herein described may have an important bearing upon the genesis of marked gain in weight during early pregnancy, severe nausea of pregnancy with its classic relief by eating or intravenous glucose, and the oft expressed feeling of well-being in such patients during late pregnancy. It is reasonable to relate the latter feature to the protection afforded against hypoglycemic insults by the metabolic changes which characterize pregnancy.

Laboratory Studies

Hyperglycemia in the fasting state—that is, in excess of 120 mg. per hundred cubic centimeters by the Folin-Wu method—was noted in 46 patients. Only 24 were known to have or were previously suspected of having diabetes mellitus.

Glucose tolerance tests during the morning were carried out in 153 patients by standard methodology. The studies were generally planned to last four to six hours. The test had to be prematurely interrupted in nine patients, however, because of the severity of the induced hypoglycemic reactions, ranging up to hypoglycemic coma and transient cardiac arrest. Attempts were made to avoid or minimize carbohydrate restriction prior to such testing. Impaired glucose tolerance—that is, greater than 180 mg. per hundred cubic centimeters at any time or greater than 130 mg. at 3 hours—was present in 81 patients. The average blood glucose concentrations (milligrams per hun-

dred cubic centimeters, Folin-Wu) in the diabetic and nondiabetic groups were as follows:

	Diabetic	Nondiabetic
	Group	Group
Fasting	112	106
1 hour	196	150
2 hours	151	111
3 hours	117	91
4 hours	91	78
5 hours	75	86

The lowest individual concentrations encountered in the diabetic and nondiabetic groups were 48 mg. at four and one-half hours and 30 mg. at three hours, respectively.

Glucose tolerance tests during the afternoon were performed on 27 patients. All had eaten a breakfast at least four hours before ingesting 100 Gm. of glucose, and then remained active before and during the test. The average blood glucose concentrations (milligrams per hundred cubic centimeters, Folin-Wu) in the diabetic and non-diabetic groups were as follows:

	Diabetic Group	Nondiabetic Group
Fasting	103	89
1 hour	209	134
2 hours	149	106
3 hours	107	86
4 hours	72	67

Such study resulted in the following two important findings: (1) 10 patients, most with histories of diabetes mellitus in their immediate relatives, evidenced unequivocally impaired glucose tolerance only during the afternoon, but not during the morning, and (2) these patients almost universally experienced marked intensification of their hypoglycemic response to glucose loading under these circumstances, the reaction simulating that of the spontaneous attacks in every detail. For example, the comparative morning and afternoon glucose tolerance tests of case DN-34, a 38 year old woman with classic narcolepsy, an active duodenal ulcer, severe recurrent hypoglycemia and a maternal history of diabetes mellitus, were as follows:

	Test Begun	Test Begun
	at 8 a.m.	at 11:30 a.m.
	2/12/63	2 22/63
Fasting	83	80
½ hour	121	194
1 hour	105	262
2 hours	78	232
3 hours	62	110
4 hours	71	30*
5 hours	77	

^{*}Accompanied by a severe hypoglycemic reaction.

These observations are consistent with my convictions that (1) diabetes mellitus is essentially a

disease of "high-output failure" of insulin release and not of deficient insulin production, a belief which is clearly supported by the insulin-like activity studies to be cited, and (2) afternoon glucose tolerance testing is more "physiologic" than cortisone-glucose tolerance testing in evoking this metabolic aberration.

Serial serum potassium levels were determined before and hourly for four hours after glucose loading in 31 patients. With four exceptions, the concentrations declined from an average fasting level of 4.87 mEq/L to 4.11 mEq/L. (See case history of DN-30.) The greatest single decline was 1.4 mEq/L. There was no significant difference in the decline among the diabetic and non-diabetic groups.

Serial serum sodium levels were determined fasting and hourly for four hours after glucose loading in 12 patients. They rose an average of 2.1 mEq/L after glucose in eight of these patients. (See case history of DN-30.) As indicated earlier, there was an associated recurrence of abdominal distention and edema, namely, a gain in weight up to 5 pounds, during the next 24 hours in several patients.

Serial serum calcium levels declined an average of 0.35 mg, per hundred cubic centimeters in 14 patients whose concentrations were determined fasting and at two hours and four hours after glucose loading.

Studies of adrenal function, pituitary reserve, or both, were carried out in 15 patients. These tests included several or all of the following: determination of the urinary excretion of 17-ketosteroids and 17-hydroxycorticoids before and after corticotropin; similar urinary steroid assay before and after intravenous or oral methopyrapone (Metopirone); urinary catecholamine excretion; the eosinophil response to corticotropin; the 24 hour urinary excretion of aldosterone; and the determination of serum electrolytes. With two possible exceptions, these studies indicated the presence of normal adrenal function and adequate pituitary reserve. Case DO-39, a 41 year old obese, diabetic and hypertensive woman with long-standing narcolepsy, severe recurrent hypoglycemia and familial hirsutism had a daily catecholamine excretion of 15 mg. and slightly elevated excretion of both 17 - ketosteroids and 17 - hydroxycorticosteroids. Numerous studies, including dexamethasone suppression and culdoscopy, failed to indicate the presence of an adrenal or ovarian tumor. Similarly, the urinary steroids were elevated in a

markedly obese 34 year old man (case NO-44) with severe recurrent hypoglycemia and classic narcolepsy. As the hypoglycemic symptoms abated and his weight declined, the urinary 17-ketosteroids and 17-hydroxycorticosteroids normalized. The increased adrenocortical response that occurs in obese persons and as a result of hypoglycemia has been documented by others.²⁰⁻²²

X-rays of the skull and sella turcica were normal in the 29 patients so studied.

Studies of thyroid function were carried out in the majority of patients in this series. These parameters included determination of the protein-bound iodine or butanol-extractable iodine concentrations, the serum cholesterol, the timed Achilles tendon reflex (SD interval), and radio-active iodine uptake. All of these studies were essentially within normal limits except in one patient who had been subjected to two thyroidectomies, three patients with iatrogenic hypothyroidism, and one patient with diffuse hyperthyroidism.

Serial serum insulin-like activity assays were determined by the rat epididymal fat pad assay method on specimens obtained fasting and at one-half hour, one hour, two hours and in several instances four hours after ingestion of glucose in 21 patients. The fasting concentrations were normal in all patients except for two in whom they were slightly below the lower limits of normal. As expected,²³ the post-glucose levels rose, the increase being particularly striking in the diabetic or potential diabetic patients (fig. 1), even when impaired glucose tolerance during the morning could not be demonstrated. In many instances, subsequent afternoon glucose tolerance testing confirmed the diabetic diathesis when large amounts of insulin were present in response to morning glucose loading.

The aforementioned concept that diabetes mellitus is largely a "high-output failure" of insulin release appears to be further supported by comparative insulin-like activity assays carried out in patients with "early" previously unsuspected diabetes. For example, case DO-71 demonstrated impaired glucose tolerance in both the morning and afternoon glucose tolerance tests. They were characterized by glucose concentrations exceeding 200 mg. per hundred cubic centimeters in both studies, and a precipitous decline between the third and fourth hour in the morning study and between the second and third hour in the after-

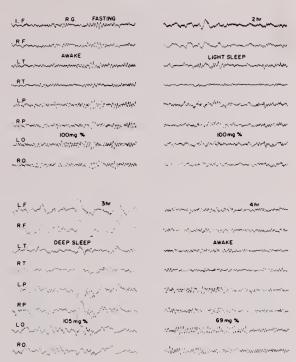


Fig. 2. — Sequential electroencephalographic response in a nondiabetic and narcoleptic patient after the ingestion of glucose.

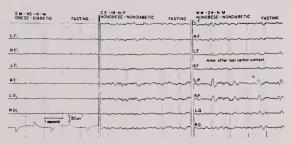


Fig. 3. — Low voltage pre-glucose electroencephalograms in three Negro patients with severe narcolepsy and recurrent hypoglycemia. Note the prompt onset of parietal "humps" and sleep spindles in patient W.W.

noon study. The comparative insulin-like activity levels (γ units/ml.), however, were as follows:

	Morning Study 12/12/62	Afternoon Study 1/2/63
"Fasting"	494	2148
½ hour	439	1466
1 hour	657	1466
2 hours	1208	697

Pulmonary function and cardiac catheterization studies were performed in two patients. These included the determination of arterial oxygen saturation and carbon dioxide pressure at rest, after the inhalation of 5 per cent carbon dioxide, and after the administration of a respiratory stimulant (AHR-619). In an obese young white woman (case DO-25) with the entire syndrome,

but without clinical evidence of heart disease, the resting arterial oxygen saturation was 90 per cent. She demonstrated a prompt response to both the inhalation of 5 per cent carbon dioxide and the respiratory stimulant, the arterial oxygen saturation rising to 94 per cent in each instance.

Electroencephalographic Studies

Electroencephalograms were recorded before and after glucose loading for periods of four to five hours in 14 patients, and for periods of one and one-half to two hours or longer in 48 patients. The standard monopolar recording technic with 14 electrodes was used, all measurements being made on an 8-channel Grass unit (Model III D). With the exception of 13 patients in whom the study was either unsatisfactory for technical reasons (namely, claustrophobia, tension associated with pressing business commitments, and the failure of one Negro woman adequately to cleanse her scalp of oil) or who had received dietetic and analeptic therapy for periods ranging from two weeks to six months, every patient demonstrated progressive drowsiness and sleep within one-half to two hours following glucose ingestion. This response was evidenced both clinically and by sustained replacement of the occipital alpha rhythm with low-voltage slow waves, and then by the appearance of striking parietal "humps" and sleep spindles (figs. 2 and 3). The profound low-voltage and pre-glucose sleep patterns (fig. 3) that characterized the electroencephalograms of several Negro patients were noteworthy; comparable records were not found in the many more white narcoleptic patients who were studied under identical circumstances.

Most patients subsequently evidenced increasing "alertness" in the form of a return of occipital alpha rhythm, frequent eye blinking, and muscle tension artifacts. The observed changes in cortical activity were decidedly related to decreasing blood glucose concentrations, but could not be correlated with specific levels in every instance, especially among the diabetic patients. The threshold, however, appears to be about 70 mg. and *not* 50 mg. per hundred cubic centimeters. This fact was clearly recognized both by Cannon²⁴ and by Harris²⁵ more than three decades ago. The characteristic correlative sequence in a nondiabetic patient is depicted in figure 2.

Small doses (2.5 to 5 mg.) of intravenous methylphenidate hydrochloride* administered into

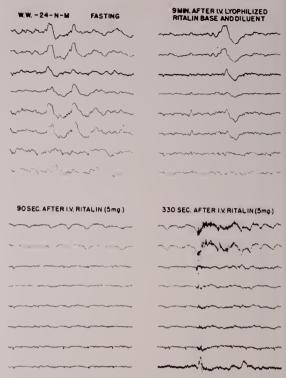


Fig. 4. — Analeptic response to intravenous methylphenidate hydrochloride during narcoleptic sleep. Note the absence of a response to the lyophilized methylphenidate hydrochloride base and diluent.

the side tubing of a continuous saline infusion at the height of narcoleptic sleep caused striking cortical activation within 30 seconds to three minutes (fig. 4). There was no response to a preceding control infusion of the lyophilized methylphenidate hydrochloride powder base mixed with the methylphenidate hydrochloride diluent.

Activation was also produced within three to five minutes after injection of 20 units of regular insulin intravenously (fig. 5). This observation has been made by others.²⁶ The activation induced by intravenous tolbutamide (Orinase)** in two patients was much less impressive and delayed, in contrast with the insulin studies. It did not occur until the blood glucose concentrations were below 70 mg. per hundred cubic centimeters.

The most striking electroencephalographic findings in these patients was the presence of unequivocal and multiple dysrhythmias in 45 patients (72.6 per cent) of the 62 so studied. These dysrhythmias consisted chiefly of diffuse paroxysmal spike activity in 32 patients, occasional to frequent bursts of low-voltage, fast (20-30/sec.) activity over the frontal and parietal areas in 27 patients, diffuse paroxysmal high-voltage slow-

^{*}Methylphenidate hydrochloride (Ritalin) kindly supplied by Ciba Pharmacentical Company, Summit, N. J.

^{**}Tolbutamide (Orinase) kindly supplied by The Upjohn Company, Kalamazoo, Mich.

ing (over the parietal and midtemporal areas in particular) in 16 patients, and either 14-and-6/sec., 14/sec., or 6/sec. activity in nine patients. Some of these dysrhythmias are depicted in figure 6. A "mitten" pattern was present in two patients. Abnormal frontal and parietal fast activity was accentuated by hyperventilation in two patients. Case DO-78 briefly exhibited a psychomotor variant pattern. It is pertinent that a history of clinical seizures could be elicited from only two patients in the entire series.

The unanticipated high incidence of dysrhythmias is logically attributable to the cerebral insults incurred by repeated hypoglycemia over prolonged periods. This conviction is supported by numerous electroencephalographic observations in diabetic patients who have experienced severe insulin reactions,²⁷ patients with functioning isletcell tumors,²⁸ and the effect of blood sugar declines on petit mal epilepsy.²⁹ It is also of interest that the several diabetic patients without a dysrhythmia were either young obese patients who habitually consumed much sugar or known diabetic patients receiving insulin who scrupulously avoided insulin reactions, irrespective of their blood sugar concentrations.

Representative Case Reports

Case DN-30.—Woman with presenting severe tremor, psychiatric features, and recurrent hypoglycemic symptoms; associated narcolepsy, recurrent edema, tachycardia and "hot flushes;" family history of diabetes mellitus and narcolepsy; repeatedly diabetic glucose tolerance tests and a severe dysrhythmia; gratifying clinical and electroencephalographic improvement on a comprehensive regimen.

This 38 year old housewife was seen in consultation at the request of her attending psychiatrist for "refractory tetany" and failure of her "deep-seated emotional disturbance" to respond to formal psychotherapy, a wide variety of psychotherapeutic drugs, and electric shock therapy. The patient stated that she had begun to experience increasingly disabling symptoms about one year previously. They included the following: (1) bouts of intense "hot flushes" and profuse sweating, especially during the early hours of the morning; (2) increasing "nervousness;" (3) severe tremulousness with predictable exacerbations at certain times, namely, during the middle or late afternoon and about 9 p.m.; (4) occasional bouts of rapid heart action; (5) early morning insomnia; (6) recurring abdominal discomfort that had been once diagnosed as an "early developing peptic ulcer;" (7) recurrent swelling of the abdomen, unrelated to her regular and normal periods; and (8) a tendency to urinate excessively.

A tendency to "poor concentration," evident since her teens, was becoming worse. She would repeatedly fall asleep while watching television. She experienced considerable difficulty on attempting to read a newspaper or book because the words soon became blurred. On direct questioning, she promptly admitted to having frequent hypna-

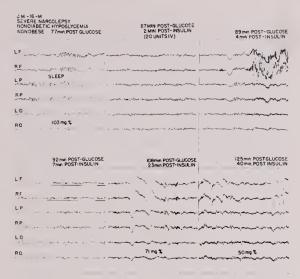


Fig. 5. — Analeptic response to intravenous regular insulin in a nondiabetic narcoleptic man during glucose-induced sleep. Note the promptness of the cortical activation and its intensification with the progressive decline in blood glucose concentration.

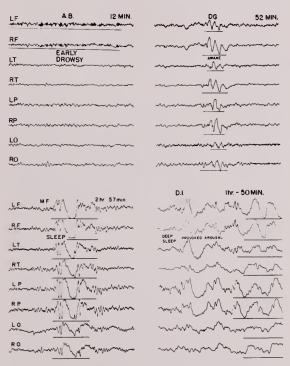


Fig. 6.—Representative dysrhythmias, including low-voltage fast (20-30/sec.) discharges (chiefly over the frontal and parietal leads), paroxysmal diffuse slowing, and paroxysmal spike activity.

gogic hallucinations chiefly auditory in nature, vivid dreams generally associated with early morning wakening, and cataplexy.

The past history included a vague episode of "brain fever" during childhood, and migraine headaches for many years. She smoked about one-half package of cigarettes daily. She frequently ate candy or food containing considerable sugar for the "lift" thereby derived. Breakfast was often omitted. A history of diabetes mellitus in

several members on the maternal side of her family was elicited. The patient's two children had both been rather sizable at birth—averaging eight and one-half pounds—considering her weight of only 110 pounds prior to pregnancy. Her mother "always" required frequent naps. Her 16 year old son had been an honor student, but was recently doing poorly in school because he could not "concentrate."

Numerous tests had been performed prior to this consultation. X-rays of the upper gastrointestinal tract and gallbladder were normal. The cerebrospinal fluid and serologic tests gave normal results. A five hour glucose tolerance test in June 1962 had given the following results: fasting, 91 mg. per hundred cubic centimeters (Folin-Wu method); one-half hour, 181 mg.; one hour, 245 mg.; two hours, 248 mg.; three hours, 145 mg.; four hours, 97 mg.; and five hours, 51 mg.

Physical examination revealed few pertinent findings. The patient weighed 101 pounds. The systolic blood pressure was 112 mm. Hg sitting, and declined 10 mm. Hg on standing. The results of funduscopic and neurological examinations were specifically within normal limits.

A complete blood count, the serum calcium concentration, liver function studies, thyroid function studies, urinary catecholamines, urinary 17-ketosteroids and 17-hydroxycorticosteroids, urinary serotonin, and skull films were within normal limits. Porphobilinogen was absent in the urine. A repeat five hour glucose tolerance test during the morning with concomitant determination of the sodium and potassium concentrations gave the following results:

	Blood Sugar (mg.%)	Urine Sugar	Sodium (mEq/L)	Potassium (mEq. L)
Fasting	108	0	137.5	4.5
1 2 hour	268	2+	137.0	4.1
1 hour	264	3+	141.0	4.3
2 hours	228	3+	141.0	4.15
3 hours	135	0	140.0	4.2
4 hours	53	0	140.0	4.4
5 hours	67	0	143.0	3.9

During the early part of this study, the patient became progressively sleepy. After two hours, however, she commenced to experience progressively severe shakiness comparable in every respect to her "tetany," drenching sweats, and an intense throbbing headache. She also volunteered that she had much trouble obtaining a urine specimen both during the test and for several hours thereafter. Owing to the intensification of her hypoglycemic symptoms during the afternoon, an afternoon glucose tolerance test was performed, starting at noon after she had eaten a breakfast and remained active. The results were as follows: initial specimen four hours after breakfast, 103 mg. per hundred cubic centimeters; one hour, 187 mg.; two hours, 131 mg.; three hours, 128 mg.; and four hours, 69 mg. On this occasion, the drowsiness was short-lived, and her tremulousness and headache became intensified at about two and one-half hours. A striking dysrhythmia was present, consisting of bilateral or alternating diffuseparoxysmal slow wave discharges (fig. 7).

A program was prescribed which included strict abstinence from sugar and concentrated carbohydrate, adequate meals to be eaten on time, snacks every two to two and one-half hours during the day and night, cessation of smoking, diphenylhydantoin (Dilantin), 0.1 Gm. thrice daily, and parenteral nandrolone phenpropionate (Durabolin), 25 mg., with vitamin B₁₂, 1,000 mcg., weekly. On this program, the patient experienced a dramatic remission of all the presenting and major symptoms. If she delayed taking an in-between-meal snack for three hours or longer, however, the tremor and headache would promptly recur. She also experienced a dramatic analeptic effect with methylphenidate hydrochloride, 5 mg. thrice daily. After she had been relatively symptom-free for three months, she noted that the drowsiness was subsiding and that less of the drug was required. A repeat electroencephalographic study revealed a decrease in the frequency of the paroxysmal discharges.

Case NO-1.—Narcolepsy, functional nondiabetic hyperinsulinism, obesity, migraine and recurrent edema in a young woman with presenting tachycardia due to unnecessary thyroid therapy; gratifying response to dietary and analeptic treatment.

This 29 year old cashier sought consultation because of intermittent attacks of rapid heart action. She had been taking thyroid substance, 180 mg. daily, for one year. A diagnosis of hypothyroidism had been previously made on the basis of obesity, "fatigue," and the presence of a goiter. A pretreatment protein-bound iodine level, however, was 5.4 mcg. per hundred cubic centimeters. The goiter was known to have been present for over 10 years. She had been overweight since her teens.

On direct query, the patient admitted to increasing drowsiness, particularly during the midmorning and after lunch. She remained "tired" even after sleeping eight to 10 hours, notwithstanding the absence of emotional difficulty, boredom or excessive physical activity. The drowsiness was actually impairing her ability to drive safely. She also experienced cataplexy, vivid dreams, and often awakened during the early morning hours "with a start." Although she repeatedly experienced marked nervousness, "jitteriness" and hunger at about 10 a.m. and 3 p.m., she avoided eating at these times because of her fear of putting on more weight. Other complaints included typical migraine, easy bruising, and a tendency to accumulate considerable fluid suddenly, but without relationship to the menses. Previous infections with mumps and chickenpox were uneventful.

Physical examination revealed a markedly obese young woman with a diffusely enlarged thyroid. Her height was 5 feet 6 inches. She weighed 1961/2 pounds. The body frame was large. There were no convincing clinical features of either hyperthyroidism or hypothyroidism. The SD interval (timed Achilles reflex) before discontinuing thyroid was 0.20 second on the left and 0.22 second on the right. The blood glucose concentrations (Folin-Wu) after ingestion of 100 Gm. of glucose were as follows: fasting, 105 mg. per hundred cubic centimeters; one hour, 149 mg.; two hours, 126 mg.; three hours, 115 mg.; and four hours, 70 mg. She fell asleep during the second hour of the test. Thereafter, she became increasingly alert and experienced severe hunger, sweating, nervousness and tremulousness shortly after the four hour specimen was drawn. The cholesterol level was 230 mg. The butanolextractable iodine level was again 5.4 mcg. Paroxysmal high-voltage spike discharges were recorded over the left and right frontal leads during glucose-induced drowsiness and sleep.

The thyroid medication was uneventfully discontinued. Small doses of methylphenidate hydrochloride, 2.5 mg. before breakfast and lunch, resulted in gratifying improvement of the drowsiness-a change that was promptly noticed by her husband and her business associates. An increase in the dosage to 5 mg, twice daily proved even more effective. By both abstaining from sugar and taking in-between-meal snacks-chiefly as formula (Metrecal) wafers-she experienced no further hypoglycemic attacks. A concerted effort at reduction in weight, however, was delayed for two weeks. At that point, the weight had climbed to 2001/4 pounds, and it was evident that standard hypocaloric dieting alone would not suffice. A program of liquid formula thrice daily combined with formula wafers between these feedings and at bedtime was then instituted. Over the ensuing several weeks, the weight declined to 1853/4 pounds; she continued to work during this time and felt exceedingly well. After one month on a standard hypocaloric diet with interval feedings, she weighed 178 pounds. An attempt to reduce the dosage of methylphenidate hydrochloride was promptly followed by recurrence of the drowsiness. Two months later, the weight had declined to 170 pounds, and she remained asymptomatic.

Management

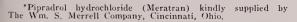
Only the more important aspects of managing this syndrome will be reviewed. While these patients always need reassurance, and while psychotherapy or environmental manipulation and readjustment are often indicated, the physician also must often change his orientation if therapy is to be most beneficial. For example, it has become necessary for me to challenge the gospel of the leading proponents of the psychosomatic approach to the understanding and treatment of disease—"not de-emphasizing the soma, but emphasizing the psyche"—by my conviction concerning the importance of "not de-emphasizing the psyche, but emphasizing the *treatable* soma" in managing this disorder and its complications.

Recurrent hypoglycemia can be controlled by a high protein and low carbohydrate diet that is devoid of sugar and sweets. It should also encompass the concept of "scientific nibbling" in the form of seven or more feedings per day. Most patients require snacks at more frequent intervals as the day progresses because of their accelerated hypoglycemic response (vide supra).

Owing to its relatively high protein and low fat content, a dietary formula (Metrecal) in liquid, wafer, soup or casserole form has proved eminently helpful and convenient in managing recurrent hypoglycemia in these patients when they are overweight. This technic was particularly appreciated by male patients. Patients were also supplied with a list of relatively inexpensive sugarfree foods such as matzos, LaRosa dietetic egg biscuits and low calorie vegetables which are readily available in local markets and which could be used for weight control.

Methylphenidate hydrochloride has proved to be an effective analeptic agent which does not have significant sympathomimetic side effects in the dosages employed. Most patients proved remarkably responsive to relatively small amounts, generally ranging from 5 to 10 mg. before meals two to three times daily. Pipradrol hydrochloride (Meratran)* has been occasionally preferred to methylphenidate hydrochloride, but the converse was usually found to be the case. Some patients required as much as 60 to 80 mg. of methylphenidate hydrochloride daily.

Inasmuch as these patients are not usually hypothyroid, thyroid therapy should be discontinued as soon as possible. If permanent iatro-



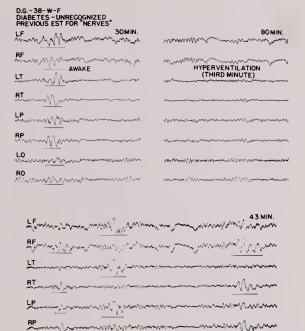


Fig. 7. — Diffuse dysrhythmia in case DN-30. See text.

ALL TO LOW MID-OCCIPITAL REFERENCE

genic (radiation, surgical, drug) hypothyroidism does exist, replacement therapy is required.

Excessive smoking should be specifically curtailed since this habit can cause or aggravate post-prandial hypoglycemia.³¹ These patients should avoid alcoholic beverages, excessive caffeine and cola-containing liquids for similar reasons.^{32,33}

The so-called anorexigenic drugs related to amphetamine should be avoided. It is my conviction that the widespread use of these agents by obese persons over prolonged periods can be directly attributed in most instances to the analeptic effect achieved thereby for unrecognized narcolepsy. The same consideration may also apply in the case of amphetamine addicts.

Patients who are subject to recurrent edema should be counseled concerning the avoidance of the excessive ingestion of both salt and free water, and lying down during the day—along with the aforementioned measures. Diuretic agents should be avoided or minimized in such patients, especially during the hot weather when a low sodium diet is being followed.

By recognizing underlying diabetes mellitus before it has become manifest in its classic form, measures may be instituted that can prevent, minimize or delay both its clinical onset and complications. This is especially important in the case of youth-onset diabetes before the patients "decompensate." Stress should be placed upon adequate reduction in weight, the prevention of obesity, and the strict avoidance of symptomatic hypoglycemia. I have elsewhere cited observations concerning the unequivocal aggravating effect of hypoglycemia on diabetic retinopathy, 34 and my belief that recurrent hypoglycemic stress with its various endocrine and metabolic sequelae probably plays a crucial role in the actual genesis of diabetes mellitus.35 Attempts were made to treat several "early" diabetic patients in this series with either tolbutamide or phenformin hydrochloride (DBI), chiefly because of their purported beneficial effect during this crucial period.^{36,37} Owing to the intensification of hypoglycemic symptoms and the ensuing clinical exacerbation in these patients, however, these drugs have since been withheld.

Antiepileptic therapy consisted of diphenylhydantoin given to selected patients with demonstrable dysrhythmias when episodic headaches, severe anxiety, other neurologic or psychiatric features, or the desire to resume alcohol did not respond completely to the basic program outlined. The dosage was generally 0.1 Gm. thrice daily. These experiences support those of others who have observed clinical and electroencephalographic improvement in patients with labile diabetes following the administration of anticonvulsive therapy.³⁸

Nandrolone phenpropionate* proved helpful in managing the neuropathies of many of these patients—both diabetic and nondiabetic—after standard measures, such as parenteral vitamin

*Nandrolone phenpropionate (Durabolin) kindly supplied by Organon Inc., West Orange, N. J.

B₁₂, multivitamins and the avoidance of leg crossing, had proved ineffective. The dosage ranged from 12.5 to 25 mg. intramuscularly, the drug being given initially every five to seven days into the deltoid area. Marked relief of neuritic discomfort was generally forthcoming within three to four weeks. In many instances, such benefit was either accompanied by or followed a significant decrease in the SD interval. A recurrence of symptoms—with prolongation of the SD interval in some instances—was repeatedly forthcoming when nandrolone phenpropionate was prematurely discontinued or given at prolonged intervals too early in the course of treatment.

Summary

The syndrome of true narcolepsy and recurrent hypoglycemia associated with functional hyperinsulinism or diabetes mellitus is described, along with its salient pathogenetic and complicating features. The latter include obesity, vascular headaches, cerebral dysrhythmias, peripheral neuropathies, angina pectoris, cardiac arrhythmias, "refractory" peptic ulcer, and alcoholism.

The clinical, laboratory and electroencephalographic data obtained in 190 such patients are reviewed. Particular reference is directed to the need for recognizing this disorder in the children of these patients and in Negroes.

A rational program of therapy and prophylaxis based on these observations is set forth.

References are available upon request from the author.

The laboratory assistance of Mrs. Martha Wentworth and Mrs. Adele Gold, and the assistance of Miss Mary Ann Little and Dr. William H. Everts in recording and interpreting the electroencephalograms are gratefully acknowledged. I am also grateful to Dr. Buris R. Boshell for performing the insulin-like activity assays, and to Dr. Philip Samet for performing the pulmonary function and cardiac catheterization studies.

300 Twenty Seventh Street.

Volume 50 of The Journal, which began with the July issue, will end with the December, 1963, issue, allowing only six instead of the usual 12 numbers. The House of Delegates in session at the Annual Meeting approved the resolution, originating within the Hillsborough County Medical Association, which directed that each volume begin with the calendar year in order to correspond with the other activities of the Florida Medical Association.—T.M.

Fatal Anaphylactic Reactions Due to Penicillin

ARTHUR FREDERICK SCHIFF, M.D. MIAMI

Although it may appear old hat to some and others may raise their eyes to heaven with a "What, again?", nevertheless the cold fact that lives are still being lost because of penicillin anaphylaxis makes this article timely and pertinent. In one county (Dade), in one state (Florida), within a period of five years, nine known deaths have occurred.1.2 The Cumulative Index Medicus lists increasingly more cases of severe and fatal anaphylactic shock due to penicillin. Many authorities agree that "the incidence of anaphylactic reactions to penicillin is on the increase."3 At the National Congress of Coroners held in Chicago in 1962, Dr. Alan R. Feinberg, Professor of Allergy, Northwestern University, declared that penicillin is "the major cause among drugs of acute and fatal allergic reactions." Admittedly, the percentage of deaths is exceptionally low when one considers the millions and millions of penicillin doses given all over the country every week; nevertheless, one death caused by failure to question the patient fully, one death caused by failure to perform a scratch test is one death too many.

Of all the antibiotics, penicillin continues to be the oldest,⁴ the cheapest, the most widely used,⁵ the most effective, and the least toxic. Unfortunately, it continues to be the most allergenic. Although four types of allergic response to penicillin are known, this article is concerned with the most serious: immediate anaphylactic reaction. Flippin⁶ stated that "approximately 10 per cent of such reactions end fatally."

The following new cases in our series are presented to demonstrate the typical pattern which has emerged. Usually the patient presents himself with a disease in which the use of the drug in the first place is questionable. The disease may be viral in origin, yet someone may justify the use of penicillin to "ward off secondary invaders." Or, somehow, the magic word "prophylactic" may enter the conversation. Either a physician or his nurse administers the antibiotic without any type of skin or conjunctival testing. It appears, from statements taken after the incidents, that some attempts, however cursory, had

been made to question the patient concerning past allergies. In this series, there were statements to the effect that the patient had received the antibiotic previously without difficulties.

Report of Cases

Case 7 is that of a 52 year old Negro who was seen in a doctor's office two days before the fatal episode for a "mild upper respiratory infection" and was given 300,-000 units of penicillin G plus 0.5 cc. of Benadryl in the same syringe. He returned for a second injection which he received in the left arm. The nurse left the patient in the waiting room. A very short time later, the patient was observed shaking and acting as though he wanted to vomit. The nurse sent for the doctor, but the patient had expired. The important point of the autopsy was the finding of supraglottic edema of the larynx. The case was signed out by the Medical Examiner's office as "acute anaphylaxis secondary to penicillin therapy for upper respiratory infection."

Case 8 concerns a 62 year old white woman who visited her physician because of a sore throat of three days' duration. Examination showed an erythematous mucosa of the throat without lymphadenopathy, a temperature of 97.8 F., a blood pressure of 140/80 mm. Hg, and clear lungs. The patient was given 600,000 units of Crysticillin in the right buttock by the nurse. Within less than five minutes, while the patient started rearranging her clothes, she complained of "nervousness," tightening in the chest, and shortness of breath. She became cyanotic and collapsed. Despite an intravenous injection of 50 mg. of Benadryl, a 1 cc. (1:1,000) intracardiac injection of adrenalin, and external cardiac massage, the patient expired. Statements were made that the patient had no past allergies, had received numerous penicillin injections previously, and had herself requested the fatal injection.

The Medical Examiner reported "edema of the larynx, acute pharyngitis, and edema of the lungs." He added, "As a result of this considerable edema, the air passages are extremely narrow at the level of the vocal cords and reduced to one to two millimeters in their widest portions."

Case 9 deals with a 75 year old white man who came to his osteopathic physician complaining of chills, fever, difficulty in breathing, and severe coughing. The temperature was 99 F., and rales were heard throughout the lungs. An intramuscular injection of 600,000 units of procaine penicillin G was given in the left arm. In approximately five minutes, the patient started coughing, stating that he felt "funny" and his throat was dry. Oxygen and mouth to mouth breathing were administered with no success.

Autopsy demonstrated angioneurotic edema of the larynx associated with penicillin therapy.

Case 10, the last in this series, was thought to be a borderline case and led to some discussion as to whether it should be included here. A 74 year old white man was given 300,000 units of penicillin intramuscularly by his dentist for an abscessed tooth. Within one or two minutes, he became dyspneic, vomited, and was pulseless. Oxygen, artificial respiration, and external cardiac massage were employed. The patient was moved to a hospital with a diagnosis of possible coronary infarction. An electrocardiogram revealed an old anterior infarction and

"possible acute bilateral infarctions." One hour and twenty minutes after reaching the hospital, the patient expired. Autopsy showed the primary cause of death to be "acute pulmonary edema with anaphylactic reaction to penicillin, probable." Although the patient previously had been treated for asthma, he had denied penicillin sensitivity.

Comment

Penicillin, a two-edged sword, continues to take its toll of lives. As it comes to be more widely used, still more deaths will occur. The uses of penicillin are manifold. Besides being employed as a highly therapeutic agent in definitely indicated areas, it has found a place as a test for kidney excretory function; in animal experiments, penicillin G is being administered before surgery in the hope of suppressing staphylococcal infection.

It appears elementary and superfluous to state that certain precautions should be recognized and practiced in administering penicillin. Nonetheless, judging from personal observation and the literature, it seems that not only are the recommended precautions not taken seriously, but many physicians and nurses have only the vaguest idea of what it is all about.

It should go without saying that if the antibiotic is not needed and can do no good, it should not be employed. It is not the panacea we are sometimes inclined to think it is; it is not the answer to everything as the layman would like to believe; it is not the all-inclusive miracle drug the lay press states it to be. For the physician who wants a swift recovery for his patient, great is the temptation to use the antimicrobial in febrile respiratory illnesses, in trivial skin infections, as "shotgun" therapy in slight fevers of unknown origin, as "prophylaxis" in surgery, and especially, in the common cold. Penicillin has even been used in a case of parotitis.⁹

In their brief but excellent study, Townsend and Radebraugh¹⁰ have shown that "chemoprophylaxis does not provide the patient or the physician security against the development of complications of the usual febrile respiratory illnesses." In addition, they have learned that "it does not alter the duration of the usual respiratory illness."

A probing history by the physician himself is the sine qua non of penicillin administration. Questions should cover any past allergies or sensitivities to penicillin or other antigens. Has the patient ever had a serum sickness type of reaction; what allergies, if any, does he have? Are there any serious allergies in the immediate fam-

ily? When did the patient receive penicillin last? Reactions have been known to occur within a month of the last penicillin injection, 11 and in our office, the rule is to test anyone whose last injection is more than two weeks away.

If the answers to these questions are not completely satisfactory, this is the place to halt. As Zimmerman¹² pointed out, if there has been any previous reaction to penicillin, re-exposure may likely produce a more rapid and violent reaction. If there is any doubt, this is the time to switch to safety; another antibiotic such as erythromycin, which has a spectrum closely resembling that of penicillin.

Testing the patient is the next step. There are several recognized tests: the skin-scratch, the conjunctival, and the "basophil serologic test." The first two procedures are not without some danger. McCuiston¹⁴ reported a near fatal anaphylactic reaction in a 61 year old man. The last procedure is completely free of risk, but is a laboratory test requiring a drop of the patient's serum, penicillin solution, and rabbit leukocytes.

Skin testing is simple, requiring no special technique or equipment. It is considered to be highly accurate and should be applied routinely to all patients scheduled for penicillin. Although it has been amply described in prior publications, 15,16 since it is the keystone of preventing anaphylactic reactions, this test bears repeating. The principle is to introduce intradermally a small amount of penicillin somewhere in the body and to observe any reactions. A syringe is filled with the penicillin to be used. The volar surface of the forearm is cleaned with alcohol and allowed to dry thoroughly; then a drop of penicillin is placed on the area. With a hypodermic needle, several short, deep scratches are made through the drop. Usually, we wait about 15 minutes to prove the reaction negative or positive. A negative reaction is the absence of a wheal, itching, or redness; a positive reaction is the presence of any one or all of these signs. If a wheal develops in less than one minute, steps are taken to terminate the test; the penicillin is wiped off, and aqueous epinephrine is rubbed into the scratches.

It should be emphasized that this test serves only one purpose, to anticipate immediate anaphylactic reactions. It will not foretell any other allergy such as the serum sickness type of reaction.

Also to be emphasized is the fact that we perform this test not only for injectable penicillin,

but for the oral and the newer "semisynthetics" as well. Batson¹⁷ discussed two fatal anaphylactic reactions to orally administered penicillin and 26 nonfatal cases. He concluded that "although the oral route seems to be safer than the parenteral, its use is not without dangers." Halpern¹⁸ has written of severe anaphylactic shock after rectal administration of penicillin, and Alphentoules¹⁹ reported similar shock after a patient took only a penicillin troche. As for the so-called "synthetic" penicillins, a definite immunological relationship has been established between them and the "natural" penicillins.²⁰ The same patients who are allergic to the latter can easily be allergic to the former.

The third step is for the physician, the responsible person, and not his nurse, to follow careful injection procedure using the patient's extremity so that should a mishap threaten, a tourniquet could easily be used. The excuse that the physician is far too busy to administer the injection—which might be the most important in the patient's life—is, to us, highly invalid. Extreme care should be exercised to avoid accidental intravenous administration.

As a further safety factor, we have the patient remain in the examination room an additional 10 minutes.

A last step is to make certain the syringe and needle are well washed with running water so that penicillin will not become a contaminant in the office. In our office, we reserve separate syringes for penicillin use; they can be used for no other medication.

Treatment of Acute Anaphylactic Reaction

Since only seconds rather than minutes will mean the difference between living and dying, the physician must act swiftly and surely from the moment the battle is joined until final victory or defeat. He must seize and hold the offensive throughout the short time allowed him. His chief weapon is epinephrine, the only medication which will act quickly enough to prevent death.

Standing beside our portable oxygen cylinder in the office is a small cigar box labelled *Emergency*. Within are tourniquets, several sterile syringes, and vials of epinephrine. Like health insurance, it is there to be used when needed. In addition, a vial of epinephrine is always taped to a new bottle of penicillin.

At the first suspicion of an anaphylactic reaction, a tourniquet is placed about the extremity between the injection site and the body. Then, 1 cc. of 1:1,000 aqueous epinephrine is given subcutaneously near the penicillin injection. If within two minutes the situation worsens, a second dose of 0.25 cc. of epinephrine is given very slowly intravenously. An open airway should be insured, and oxygen should be administered if necessary.

In our series, we note that penicillinase had been used as an emergency drug. Employing this penicillin-destroying enzyme was an unnecessary act since it works slowly and its effects are seen only in hours. As stressed previously, speed is of the essence. Furthermore, penicillinase itself has been known to cause anaphylaxis.^{21,22} Steroids, which have been used occasionally in anaphylactic reactions, work too slowly to be effective; so they, too, may be taken out of the *Emergency* box.

Summary

Needless deaths occur each year because of acute anaphylactic reactions to penicillin administered parenterally, orally, or rectally. Preventive medicine is acknowledged to be superior to curative medicine. The physician should establish for himself a certain set routine in using penicillin and thereby aid in the campaign to eliminate penicillin fatalities.

References are available from the author upon request.

1912 Southwest Seventh Avenue.

Research in the Department of Biochemistry of the University of Florida College of Medicine

Frank W. Putnam, Ph.D. GAINESVILLE

In late 1955 before the College of Medicine admitted its first students and while the curriculum was still being drafted, the Department of Biochemistry laid plans for a research program designed to parallel and support its teaching mission. Early in the morning of March 18, 1956 the first research grant was awarded to Dr. Frank W. Putnam in the presence of the Duke and Duchess of Windsor and many other notables. The occasion was the world-famous Polo Ball at Palm Beach; and the award was a \$15,000 check from the Damon Runyon Foundation, signed by Walter Winchell. The funds were granted specifically to purchase an electrophoresis-diffusion apparatus of the Tiselius type to be used for studies of the abnormal proteins produced by patients with multiple myeloma. With such an auspicious start it is not surprising that the Department of Biochemistry rapidly moved forward to a first-ranking position in protein research.

With the addition of staff members experienced in widely ranging fields of research, the program has broadened to include biochemical genetics, the mechanism of enzyme action, and the biosynthesis and metabolism of vitamins, nucleic acids, lipids, and mucopolysaccharides. research programs, though initiated with state funds, are now largely supported by grants totaling about \$200,000 annually from the National Institutes of Health and the National Science Foundation. Five postdoctoral fellows and 10 research assistants are now wholly supported through research funds, and more than a dozen graduate students are engaged in dissertation research. From Australia, Great Britain, Japan, and Holland, as well as the United States, post M.D. and post Ph.D. fellows have been attracted to Gainesville to advance their biochemical training:

candidates must frequently be turned down or deferred because the facilities are already in maximum use.

In the eight year period since the opening of the Medical School the Department has acquired perhaps the most valuable armamentarium of biochemical equipment in the Southeast. In addition to the Tiselius apparatus, major items of equipment at a cost of about \$20,000 each include: an analytical ultracentrifuge-for molecular weight and homogeneity determination of proteins and capable of 60,000 r.p.m.; the automatic amino acid analyzer-for complete amino acid analysis of proteins and physiological fluids; and the Spectrochrom—a prototype apparatus for automatic chromatographic separation of proteins, nucleic acids, and other compounds (one of five pilot models distributed for test in the nation). Other major pieces of apparatus include a preparative ultracentrifuge for plasma lipoprotein separations, gas chromatography for lipid and steroid analysis, an infrared recording spectrophotometer, and a light-scattering photometer and differential refractometer. Apparatus has either been purchased or made for electrophoresis of all types: immunoelectrophoresis, paper electrophoresis, starch gel and starch block electrophoresis, and high voltage paper electrophoresis.

The facilities for radioisotope counting are outstanding, including a variety of Geiger counters and scalers for use in tracer experiments in the medical student course, as well as in research. A recent acquisition is a liquid scintillation counter with automatic print-out equipment. Although the Atomic Energy Commission supported the tracer laboratory for student use, most of the apparatus mentioned was purchased through federal research grants; yet it serves a valuable purpose for demonstration in teaching. Thus, Florida's

Professor and Head, Department of Biochemistry, University of Florida College of Medicine, Gainesville.

doctors of tomorrow will have had firsthand experience with many of the techniques that are advancing medical science.

Of course, it is the dedication and imagination of the scientist and not the excellence of his facilities that spur the advance of science. The Department is fortunate in having secured for its staff men who have had graduate and postdoctoral training in the breeding grounds of modern science: the University of Chicago, Harvard, Yale, Cambridge, the Institut Pasteur at Paris, and the Istituto Superiore di Sanita at Rome. Every appointee at the level of assistant professor or higher has held a nationally awarded postdoctoral fellowship, usually at a foreign university. All but one of the initial staff had worked with Nobel laureates. It is not surprising that the new staff members quickly instituted original investigative projects even as they worked together to develop a teaching program in keeping with the newest ideas of medical education.

Fields of Investigation

Only the perspective can be given of the widely differing fields now under study. While this perspective will emphasize lines of investigation that may contribute to medical knowledge, it should be realized that each professor is dedicated to exploring wholly new avenues of basic science now far removed from the bedside of the patient.

Professor Arthur L. Koch (B.S., Cal. Tech.; Ph.D., Chicago), winner of a Guggenheim Fellowship and of an NSF Special Fellowship for a sabbatical year at the Institut Pasteur, Paris, is undertaking biochemical studies of mutagenesis. The mechanism by which mutations occur is unknown. His principal hypothesis is that purine analogs such as caffeine exhibit their mutagenic action on bacteria by virtue of an inhibition of synthetic processes and not by incorporation into the bacterial genome. Microorganisms have been selected for study because of the ease of detection of the mutational event despite its rarity. Since mutations must involve the genetic material and hence the deoxyribonucleic acid (DNA) of the nucleus, it is necessary to isolate the enzymes involved in biosynthesis of the component nucleosides and their respective purine and pyrimidine bases. Factors affecting the flow of nutrient materials into DNA synthesis are studied by use of C14 and P32-labeled compounds. The use of purine antimetabolites enables determination of the factors holding in check each of the manifold metabolic pathways involved in DNA synthesis. It is hoped that fundamental information will thus be obtained about the regulation of DNA metabolism, a matter of importance in carcinogenesis and viral growth as well as in somatic mutations.

This long range program by no means circumscribes Dr. Koch's prolific experimentation. In the past two years he has written more than a dozen papers on such diverse subjects as: collision encounter frequency of coliphage-bacterium interaction, DNA synthesis and the mitotic cycle in Ehrlich ascites tumor cells, a method to determine inorganic sulfate in urine, the growth of viral plaques, parenchymal and littoral cell proliferation during liver regeneration, protein turnover in growing tobacco plants, and the effect of ionizing radiations and chemicals on geotropism in plants. In addition, he has contributed several important theoretical papers on the control of cell division in bacteria, the transport mechanisms in microorganisms, and the evaluation of the rates of metabolic processes from tracer kinetic data.

Professor James A. Olson (B.S., Gustavus Adolphus; Ph.D., Harvard), National Foundation Fellow at the Istituto Superiore di Sanita, Rome, has research interests in carotene synthesis, vitamin A metabolism, the role of bile acids, steroids, and the mechanism of enzyme action. The first to crystallize liver glutamic acid dehydrogenase, now of interest because of its changing specificity under the action of hormones, he studied citric acid metabolism at the International Institute for Chemical Microbiology in Rome, Italy, and cholesterol synthesis at Harvard. The range of his work in lipids is illustrated by current studies on vitamin A. By use of C14-labeled carotene and other precursors grown in molds he is able to follow the absorption and transformation to vitamin A in the intestinal tract of the rat, the transport of the labeled vitamin to the tissues, its conversion to retinene in the eye, and its ultimate urinary excretion by way of oxidation products. Vitamin A alcohol and aldehyde are available for conversion to retinene in the visual cycle and can be stored in the liver, but vitamin A acid is not. Yet, vitamin A acid appears to serve for several of the nonvisual functions of the vitamin, for example, the prevention of dermatological lesions. studying the metabolism of the acid it is hoped to unravel the multiple functions of this vitamin.

In the course of this work an important role of bile acids was discovered to be their function in promoting the intestinal absorption and metabolism of carotenes in detergent solutions. More recently it has been found that the same bile acids inhibit the absorption and transport of water soluble substances in the gastrointestinal tract, for example, glucose and amino acids. Bile acids may well have a regulatory action on the rate of nutrient absorption which has not previously been suspected.

Assistant Professor Melvin Fried (B.S., M.S., Florida, Ph.D., Yale) was a Jane Coffin Childs Fellow at Cambridge University where he worked on nucleic acid structure with Sir Alexander Todd. After further study with Professor Carl Cori at St. Louis, he returned to Florida to work in the general area of protein metabolism and function in disease states. His long term program deals with comparative structural and metabolic investigations of the various classes of serum lipoproteins that are of importance in the etiology of cardiovascular disease. Serum lipoproteins have been isolated from normal individuals with the view to ascertaining whether the protein portion is identical in all the Gofman S_f classes. A survey of lipoprotein classes in mongolism has also been initiated. With the cooperation of the Department of Pediatrics and the Sunland Training School at Gainesville, a study was made of the biochemical basis of gargoylism, an hereditary mental deficiency. As in other research in the Department, medical students collaborated in some aspects, and subsequently published papers on their findings. One student tried to devise a test for the detection of carriers of the disease. Another student received the Faculty Research Prize for his work that showed that children with the Hurler's syndrome had no detectable chromosomal abnormality. A primary current interest of Dr. Fried's is the comparative structural study of serum albumins in various species.

Assistant Professor Walter B. Dempsey (B.S., San Francisco; M.S., Ph.D., Michigan), a National Science Foundation Fellow at the University of California (Berkeley), joined the staff last year and immediately took up the study of the control of pyridoxal phosphate (vitamin B₆) levels in cells. At present the biosynthetic pathway and the mechanism for controlling the synthesis of this vitamin are unknown although it has a major function in amino acid metabolism. Dr. Dempsey has isolated the enzyme pyridoxal kinase which phosphorylates pyridoxal in the presence of ATP. He proposes now to correlate the levels of the various forms of vitamin B6 in bacterial cells and to ascertain the activities in the same cells of the three enzymes known to participate in pyridoxal phosphate metabolism. This research will require the isolation also of pyridoxamine phosphate oxidase and pyridoxal phosphate phosphatase. The effect of growth conditions on the levels of the several forms of the vitamin and of the three enzymes will also be investigated. This is yet another instance in which a bacterial system offers advantages for metabolic studies that are not presently attainable in the mammal.

Walter E. Roop (B.S., M.S., M.D., Miami; Ph.D., Florida), the newest member of the Biochemistry staff, is committed to a career of investigation of biochemical genetics in the human. For this purpose he has chosen the structural study of hereditary variant forms of plasma proteins in the manner so elegantly applied to the abnormal human hemoglobins. He has just completed a survey of the plasma of 2,600 individual blood donors in which he screened for the presence of variant forms of transferrin by use of the method of starch gel electrophoresis. Transferrin is the plasma protein that serves for iron transport to the reticuloendothelial system by combining with two ferric ions per protein molecule. Most individuals have a single type of transferrin-the normal form, transferrin C; however, some 14 types of transferrin can be demonstrated to exist under hereditary control. A heterozygous individual has two kinds of transferrin in equal amount as Dr. Roop demonstrated, one half as the normal variety, the remainder as a variety having only one or two charge differences. The situation is analogous to the abnormal hemoglobins in this respect, but thus far no deleterious effect has been attributed to the variant transferrin molecules.

Since, however, so much of modern biochemical genetics is predicated on the finding that the abnormal hemoglobins differ from the normal type A only in the substitution of a single amino acid, it is of great importance to verify that an analogous situation obtains for inherited variants of other proteins. Dr. Roop has identified 46 individuals with unusual transferrin types of four different kinds, one of which appears not to have been demonstrated previously in Caucasians. The latter protein has been compared to normal transferrin by the method of peptide mapping, the same procedure used by Ingram to establish the nature of the difference in sickle cell hemoglobin. The variant transferrin has a single peptide difference from the normal type, but the nature of the amino acid change has yet to be established.

The largest research program in the Department and the one most directly concerned with

human disease is that of the research group directed by Dr. Frank W. Putnam, Professor and Head of Biochemistry (B.A., M.A., Wesleyan; Ph.D., Minnesota). After more than a decade of study of plasma proteins and of the nature of bacterial viruses and their mode of infection, Dr. Putnam took up the study of the abnormal proteins produced by patients with multiple myeloma and related hematological disorders. While at the University of Chicago he was awarded a Lasdon Fellowship to work at the University of Cambridge with Fred Sanger, the first to determine the complete amino acid sequence of a protein (insulin). The various directions in which these studies took him are described in a separate research article as an illustration of the manner in which a basic scientist tackles a problem of clinical importance.

Teaching Mission

This summary of the current research activities of the Department of Biochemistry at the University of Florida College of Medicine by omission tends to minimize the primary teaching role of this Department and the dedication of its staff to that mission. In the basic first year medical course all staff members teach and work together with the students in lecture halls, in discussion groups, in the laboratory, and in individual conferences. Medical students though taking only the first year course may participate in departmental research in all four years; several have begun research prior to entering the college and have carried it on through the senior year. The

staff also lectures in other courses and participates in Grand Rounds and medical conferences. It performs a valuable service in consulting with clinical colleagues on the biochemical aspects of their research, sometimes leading to collaborative effort. One such example is the study of the hemoglobins in the sickling phenomenon exhibited by many deer; this project involving a herd of 40 deer is under the direction of Dr. W. Jape Taylor in the Department of Medicine, but the biochemical work is being done by Hyram Kitchen, D.V.M., a graduate student in the Department of Biochemistry under the direction of Dr. Putnam.

Furthermore, the Department, which had as its initial responsibility only the teaching of medical students, was several years ago assigned university-wide teaching in biochemistry both at the undergraduate and graduate levels. This assignment led to a sweeping revision in the biochemistry curriculum and the introduction of new courses. This work has been aided by a \$50,000 annual Training Grant from the National Institutes of Health. At present, the introductory graduate course is taught in tandem with the medical course providing for important opportunities for interchange between graduate and medical students. A postdoctoral training program involving men with the M.D., Ph.D., or both degrees is under way, and programs are also available for men in the clinical training programs. In addition to lectures, seminars, and conferences. the training programs provide firsthand research experience in all the research areas outlined.

Would You Like to Participate in the Scientific Program of the Florida Medical Association's Annual Meeting?

Participants should be members of the Association with a special interest in: 1. Pyelonephritis 2. Genetic and Developmental Aspects of Disease 3. Surgical Diseases of the Newborn 4. Functional Disorders of the Gastrointestinal Tract 5. Medical Economics 6. Adaptation of Man to Unusual Environmental Conditions.

Numerical order corresponds with participating specialties as listed: 1. Urology, Pediatrics, Pathology, Radiology 2. Obstetrics-Gynecology, Pediatrics, Radiology, Orthopedics 3. Radiology, Pediatrics, Anesthesiology 4. Surgery, Gastroenterology, Psychiatry, General Practice 5. General Surgery, Internal Medicine, Public Health 6. Otology, Psychiatry, Obstetrics-Gynecology.

Abstracts of not more than 50 words should be received by the Committee on Scientific Work, P.O. Box 2411, Jacksonville, Fla. no later than Dec. 10. They should be forwarded through the president of the particular special interest group.

RICHARD C. DEVER, M.D., CHM. COMMITTEE ON SCIENTIFIC WORK

President's Page

Now and Then

Quite often we hear from our patients questions concerning the costs of medical care. Good health is priceless! And our patients are not likely to discuss costs, according to the old German proverb, "when the tear is still mit der eye." But later, aided by subtle propaganda from various sources, they sometimes are led to believe that charges are outrageous, and that every physician is rapidly becoming rich. Some figures released by the Office of Business Economics of the U. S. Department of Commerce¹ are enlightening. They reveal very interesting facts which we can tell to the public, and the sources of information are both impartial and objective.

In 1940, four cents of every consumer dollar was spent for health; in 1960, this amount had increased to six cents. Physicians actually receive less of this in health care dollars: 25 per cent today as compared with 30 per cent 20 years before. Today, doctors average 60 hours of work each week, see more patients, try to keep abreast of new techniques, and must be knowledgeable concerning the recent advances in the profession. In order to do this, they must be better trained; and the costs of medical education have increased both in time and in money. Yet, their fees have gone up much less than the average price of all other consumer goods and services.

With the teamwork approach of modern Medicine, the patient becomes the recipient of better care in the various specialties of the profession. Greater overhead expenses, labor costs and increased costs of living apply alike to the physician and his family as to other citizen groups.

Although 20 years ago hospital costs comprised only 18 per cent of the health care dollar, these have now increased to approximately 26 per cent. And this is true for some very good reasons. Accredited hospitals must meet new high standards. There are two or more hospital employees per patient, utilizing special equipment, providing meals, comfort and special skills, doing the laundry, and performing the many services available in a good institution. Labor costs have gone up, commensurate with the costs of living. Better laboratories, with new equipment for improved diagnosis, safer treatment with antibiotic drugs, are all requisites of the modern hospital. Certainly, these things cost more money. But the results justify it, when we realize that many thousands of patients leave the hospital well, who might have died 20 years ago. In addition, the period of illness and duration of hospitalization have been reduced with the aids of early diagnosis and modern management. So, in this respect, the cost of being sick and length of time absent from work are often less now than before—an important economic factor. Yet, our patients, and some of those who have been critical, do not choose to consider these facts.

James Bryce, in March 1914, said that "Medicine is the only profession that labors incessantly to destroy the reason for its existence." This has been demonstrated once again by the constant immunization programs and by the development of protective vaccines, which prevent much serious illness. Preventive medicine and clinical research have both contributed toward extending the span of life. A child born today can expect to live seven years longer than one born 20 years ago. Certain diseases which formerly stood high in the list of killers have been tamed.

In terms of inflated dollars, it costs more now to be ill and to obtain proper care. But, while all medical costs today are 115 per cent higher than 20 years ago, and physicians' fees are up 95 per cent during this period, many other things are more

expensive. For example, according to the Bureau of Labor Statistics of the U.S. Department of Labor,² the percentage of increase in prices of food during the same period is up 150 per cent, domestic servants up 313 per cent, public transportation up 145 per cent, shoes up 174 per cent, and men's haircuts up 233 per cent, among other items.

Since people cannot estimate when or how long they will be sick, is it not logical for them to have some voluntary health insurance to help pay for these unforeseen and unanticipated health expenses, which are admittedly high? Today, voluntary health insurance pays over five and one-half billion dollars of the health care bills of insured people. It is helping greatly in meeting the increased costs of illness. Judiciously used, its premium rates can be kept reasonable. We are spending more for medical care in general, but we are buying more and better services than ever before. Doctors' fees have gone up some, but, proportionately, far less than the prices of other things we buy.

So, the next time people in your presence begin to discuss the costs of medical care, it might prove helpful to resist the natural tendency to give them a short answer. Almost invariably the noun (costs) is modified by the adjective (high). Most folks are reasonable, and will respond predictably to authentic information. Let's acquaint them with the facts.

Some years ago, Ralph McGill wrote a volume called, "The Fleas Come With the Dog."3 The author was kind enough to send me a copy which I have enjoyed reading piecemeal. The general idea is that a basic sense of values and a sense of humor can be very helpful in putting us back on the road to freedom and dignity that we started out to travel. He talks about many things, but he gives a philosophy which helps us in the solution of some of our own problems. We must face realities and fight, with modern methods, the threatening situations which are confronting Medicine. Ralph McGill says, through Uncle Cade Worley, sitting under an oak tree down in Georgia, "Big dog, more fleas." And may we add, "Let's keep scratching!"

Women wo inclian

U. S. Department of Commerce, Office of Business Economics, 1960.
 U. S. Department of Labor, Bureau of Labor Statistics, 1960.
 McGill, Ralph: The Fleas Come With the Dog. Nashville, Tenn., Abingdon Press, 1954.



Thanksgiving

It is meet and proper that the feast of Thanksgiving originated in North America—that it originated among those impoverished people whose material comforts and security would, if transferred to us, three hundred years later, evoke only the petulant whine of complaint and self pity. But not from our forebears. They were mighty men, endowed with the hard-earned wisdom of discrimination between real and ephemeral values. Perhaps because, to a large extent, they had been denied the material riches of their world, they were less susceptible to the glitter of the fool's gold with which their society rewarded its successful members. In any event, these pioneers of our civilization individually, collectively and instinctively recognized the insignificance of their physical hardships and deprivations, and the immense importance of their vast, unique gift of freedom, equality of opportunity and individual integrity. In these latter gifts they were richer than any nation on the earth, and they knew it. Their act of Thanksgiving seems to have two component parts: the first a deeply religious belief that there is indeed someone to thank for such beneficences —a superior being or God that is master of our fate and to whom we are indebted and grateful for the benevolent gift of freedom of opportunity and of choice in the conduct of our daily lives. And second, the shrewd discernment of basic values-the ability to give joyous, unrestrained thanks for the selfless and broad blessings of freedom-free enterprise, and individual dignity and determination—while standing in the swamps of poverty, insecurity and personal danger. Theirs was a rational clarity of vision, a perspicuity with which few of us are blessed today.

With the softness of character bred of today's material comforts and conveniences, and with powers of observation and decision dulled by the easy security of diminishing self sufficiency, you and I—more conscious of our "rights" than our obligations and our just deserts—find it difficult to separate the basic blessings common to all men

in our society, from the cheap, tawdry tinsel with which we, like jackdaws, adorn our nests. Our interest in a truly precious gem has been distracted by its paste imitation. Nor are we any longer easily able to invest any prayerful offertory with the religious humility and unselfish gratitude that are a part of real Thanksgiving.

Still—like our ancestors—we have the same great freedom and opportunity for which to give thanks; and we have, also, the glorious heritage they have bequeathed to us. Let us, then, on this peculiarly American day of Thanksgiving, renew our humble thanks, and our steadfast dedication for and to those great treasures of the soul which we enjoy — promising Almighty God to cherish and protect this free way of life in a violent and often vicious world.

JERE W. ANNIS, M.D. LAKELAND

Narcolepsy and Hypoglycemia

In an unusually detailed and well annotated study of his private patients, published elsewhere in this issue of The Journal, Roberts presents his criteria for diagnosis of narcolepsy and functional hyperinsulinism, representative case reports, and an outline of management of the syndrome. With the average practitioner rarely, if ever, having diagnosed narcolepsy, it is surprising that Roberts has been able to report on 190 cases personally attended; the explanation undoubtedly is the general lack of interest in or awareness of the disorder, and the failure to take an adequate history.

Bartels and Walter of the Lahey Clinic, Boston, confirmed this explanation in their paper at the 1963 annual meeting of the American Thyroid Society, noting that drowsiness was often misdiagnosed as tiredness, and that of the 124 cases of narcolepsy they studied, 41 had been previously and erroneously labeled hypothyroidism. "In this

\$76 Volume 50/Number 5

day of a trend in medicine toward diagnosis by technical methods, a disease that is diagnosed only by time-consuming history may readily be overlooked. A careful analysis of the patient's complaint, usually given as tiredness but actually being drowsiness, made the correct diagnosis possible."

The syndrome of hypoglycemia is likewise one which can be suspected only if a careful history is obtained, with note being made of the time of day and relation to meals of the patient's complaints, which may range from sweating and hunger to cardiac pain or arrhythmias and even to "black-outs," convulsions and coma. Laboratory confirmation by a five or six hour glucose tolerance test is possible with this disorder. Roberts' reasons for preferring an afternoon glucose tolerance

test are intriguing and deserve further investigation. In those patients not able to afford the necessary laboratory work, a therapeutic trial with the six (or seven) feeding low carbohydrate diet should confirm the diagnosis of hypoglycemia in a matter of days.

It is recommended that Roberts' scholarly paper be read in its entirety, both to alert the practicing physician to the common and often overlooked or misdiagnosed syndrome of narcolepsy and functional hyperinsulinism, and also to demonstrate that it is still possible for the private physician to publish worthwhile clinical observations based on his own practice.

John M. Packard, M.D. Pensacola

The Battered Child Syndrome

Since 1946, when Professor Caffey of Columbia presented a series of cases involving long bone fracture associated with subdural hematoma in children, attention has been focused more and more on the question of injuries to infants and children from birth up to three years of age where the history was obscure and where the diagnosed trauma was at great variance with the story as presented. Dr. Caffey stated at that time that any child with a subdural hematoma should have skeletal bone surveys.

Reports of cases of injuries to these infants have been appearing in the literature since that time. In 1960, Altman and Smith of the Variety Children's Hospital presented 12 cases describing the condition as "unrecognized trauma in infants." It was Dr. Kempe and his associates in Denver, however, who crystallized these reports and introduced the now accepted term "Battered Child Syndrome" into the medicolegal field. Dr. Kempe stressed, as have all the previous reporters, that the history given regarding the occurrence of the trauma is at marked variance with the extent of pathologic change. He further deplored the hesitancy of physicians in reporting these cases because of possible court appearance and fears of libel suits. A nationwide survey of hospitals regarding the incidence of these cases over a one year period was conducted and among 71 hospitals replying, 302 such cases were reported, but in only one third of these cases was proper medical diagnosis followed by some type of legal action.

Because there is no safe remedy except separation and because of the severity of the damages. the pediatricians of Florida, with Duval County in the lead, caused to be enacted in the recent legislature under Chapter 63-24 Senate Bill number 145 "an act relating to the abuse of these children and making it mandatory for physicians and institutions to report these cases and further making it a misdemeanor not to report them as of September 1, 1963."

Briefly, this is a complete and all-encompassing bill which states the following: the report must be in writing and contain first the name and address of the child and who has been his guardian, and secondly, the age and description of injuries; thirdly, and perhaps most important, the physician is guaranteed immunity from liability civil or criminal as long as the report was in good faith, denying any factor of privileged communication between doctor and patient; and finally anyone knowingly or willfully violating the provisions of this act shall be guilty of a misdemeanor. In-hospital reports must come from the physician to the administrator to the juvenile court

having proper jurisdiction. When a patient is seen in the private office, the physician or osteopath must report the case to the juvenile court judge in the county.

I would suggest printed forms in each hospital and local health department as follows:

- 1. Name of hospital or reporting physician
- 2. Child's name, age, and address
- 3. Nature and extent of injury
- 4. Evidences of previous healed injuries
- 5. Condition of child
- 6. Name of physician in charge of patient
- 7. Name of administrator, physician, or osteopath reporting the case

This form should be sent to the county juvenile court when completed.

We must remember that the purpose of the bill is to provide for the protection of children, that the physician or osteopath is guaranteed immunity, that there must be separation of the child from the parents or guardians until we have psychiatric clearance and that the local juvenile court has the power to carry out this provision either on a temporary or permanent basis.

BEN J. SHEPPARD, M.D., L.L.B. JUDGE, JUVENILE AND DOMESTIC RELATIONS COURT, DADE COUNTY CORAL GABLES

Coordinated Scientific Program for 1964 Annual Meeting

The Board of Governors of the Association, in a meeting immediately following the Annual Meeting in May, requested the Committee on Scientific Work to study the possibility of changing the format of the scientific sessions at the next meeting in May 1964. Several of the Governors pointed to the length and complexity of the meeting schedule as a factor in making attendance at the scientific program difficult for many members. A study of registration figures over the past few years shows that while membership in the Association has risen from 3,016 in 1957 to 4,757 in 1963, attendance at the Annual Meeting has remained relatively stable, averaging about 1,100 each year.

After considerable discussion with members of the Board of Governors, the President of the Association, and a subcommittee of the Council on Specialty Medicine, the Committee on Scientific Work has established the general format of the 1964 scientific program. It has been reviewed and approved by the Board of Governors at its September meeting.

Division of the scientific program into sections will be accomplished on the basis of scientific topic rather than by specialty interest. Our program will consist of three afternoon scientific sessions which will not conflict with the many business and committee sessions of the meeting. Each afternoon there will be a choice of program for those attending the scientific sessions, since there

will be two sections presented simultaneously. Each program will include both member speakers and visiting speakers. After the presentations of the speakers, the section will conclude with a panel discussion by the speakers and invited participants, and the opportunity for questions to the panel from the audience. There will be a single morning session devoted to a film program. Evenings will be open for social or specialty group functions.

The subjects to be presented, the Committee thinks, are sufficiently diversified to provide interest and stimulation to anyone who is present at the Annual Meeting. They include: "Pyelone-phritis," "Genetic and Developmental Aspects of Disease," "Surgical Diseases of the Newborn," "Adaptation of Man to Unusual Environment," "Functional Diseases of the Gastrointestinal Tract," and "Medical Economics."

Our objective has been to improve the caliber of the scientific program and, in that way, to improve the attendance at the scientific program. The members of the Committee hope that the effort which they and a great many of the other members of the Association have made will be reflected in an expanded and more educationally rewarding scientific program at the 1964 meeting.

RICHARD C. DEVER, M.D., Chairman COMMITTEE ON SCIENTIFIC WORK MIAMI



Summary of Board of Governors Meeting Held September 19-21, 1963

1964 Annual Meeting.—Adopted the format for the 1964 Annual Meeting, to be held at the Diplomat Hotel, Hollywood, as follows:

Wednesday, May 6—9:00 a.m. set up exhibits; 2:00 p.m. delegates registration begins; evening, free.

Thursday, May 7—9:30 a.m. first session House of Delegates; 11:00 a.m. Blue Shield Annual Meeting; 2:00 p.m. scientific section meetings; evening, specialty groups.

Friday, May 8—9:00 FMA scientific films; 9:00, 9:30, 10:00, 10:30 a.m., Reference Committee meetings; 11:00 a.m. General Session; 2:00 p.m. scientific section meetings; evening, President's reception, alumni and fraternity socials.

Saturday, May 9—9:00 a.m. specialty groups business meetings; 2:00 p.m. scientific section meetings and specialty group meetings; evening, specialty groups.

Sunday, May 10—9:30 a.m. second session House of Delegates; noon, dismantle exhibits; p.m. post-convention meeting Board of Governors.

Authorized first, second and third prizes for technical exhibit visitation and emphasized that only members may have their cards signed by the exhibitors.

Medicare Contract.—Approved the actions of the Medicare Negotiating Committee in signing the new contract with the Office for Dependents' Medical Care based upon the 1962 FMA Relative Value Studies. Commended the Committee and particularly its chairman, Dr. Robert E. Zellner, for outstanding work on behalf of the Association in completing the negotiation of this contract.

Conference of Presidents and Secretaries.—Approved the recommendation of the Executive Committee to hold the Sixth Annual Conference for Presidents and Secretaries of County Medical Societies, January 25-26, 1964 at the Robert Meyer Motor Hotel, Orlando. Approved the subjects and format for the meeting.

Amendments to By-Laws.—Approved recommending to the House of Delegates amendments to the By-Laws granting FMA Past Presidents full privileges in the House of Delegates (currently they have only the privilege of the floor).

Specialty Group Agreements.—Approved a revised agreement between the FMA and specialty groups, restricting the amount of service provided to specialty groups by the FMA Executive Office.

Criteria for Approval of Specialty Groups.—Adopted an additional provision for FMA approval of specialty group organizations which will require all members of specialty groups to be members of the FMA.

Ad Hoc Committee on Medicine and Religion.—Authorized the establishment of an Ad Hoc Committee on Medicine and Religion and requested the President to make appointments to this Committee.

FMA Membership Brochure.—Authorized the publication of a new membership brochure, entitled "Facts About FMA."

Professional Liability Brochure.—Authorized the publication of a brochure on professional liability for members of the Association.

Coordinating Council on TB Eradication.—Authorized the continued participation by the Association in the Florida Coordinating Council on TB Eradication and designated H. H. Seiler, M.D., and Charles R. Sias, M.D., as FMA representatives on this council.

COMAH.—Approved the reorganization of the Committee on Medicine and Hospitals and requested that it be submitted to the other member organizations for their consideration. This committee is a joint venture with other organizations for administrative services for state legislative activities.

Osteopathy.—Reviewed an inquiry from a county medical society regarding relationships between Doctors of Medicine and osteopaths and voted to advise the medical society of the pertinent paragraphs in the Principles regarding osteopathy adopted by the House of Delegates and to advise the society if any of its members are violating these principles that appropriate disciplinary action should be taken by the society.

COUNCIL AND COMMITTEE REPORTS

The Board carefully reviewed all Council and Committee reports presented and took the following actions:

Council on Allied Professions and Vocations.—Adopted the following recommendations of the Council on Allied Professions and Vocations:

That the Committee on Pharmacy be authorized to prepare an acceptable standardized prescription form according to criteria adopted by the Committee which also would be subject to approval by the Florida State Pharmaceutical Association.

That the Committee on Nursing be authorized to hold joint meetings with the new medical liaison committee of the Florida Nurses Association for the purpose of improving liaison between the two organizations.

That approval be granted to the two new study courses in the Florida Medical Assistants Association educational program, entitled "The History of Medical Terminology" and "Law and Economics in Medical Office Administration."

That County Medical Societies be encouraged to form professional liability committees or assign this responsibility to existing committees of the county medical society as has been previously requested by the Association.

Council on Medical Economics.—Reviewed the report of the Committee on Fee Schedules which advised that the negotiations of the new Workmen's Compensation fee schedule had been completed and adopted by the Industrial Commission and will become effective October 1, 1963. Commendation was extended to the Committee for its outstanding work on behalf of the Association.

Council on Medical Service.—Approved the report of the Committee on Public Health endorsing a proposal for determining the value of oral cytology techniques for early detection of oral cancer, sponsored by the Florida State Dental Society and the Florida State Board of Health.

Scientific Council.—Reviewed the report of the Committee on Scientific Work and approved the outline for the scientific program coordinated with specialty group speakers for the 1964 Annual Meeting of the Association. Commended the Committee for its work.

Council on Voluntary Health Agencies.—Reviewed the report of the Council on Voluntary Health Agencies and approved an additional criterion for official recognition of voluntary health agencies, as follows:

"Must be subject to annual reevaluation by the Florida Medical Association Council on Voluntary Health Agencies."

Adopted the recommendation of the Council "that each county medical society be requested to establish, if one does not already exist, a committee on voluntary health agencies, with which the Council can work in a consultative capacity. In those societies not large enough to appoint a committee, it is recommended that an individual physician be designated with whom the Council can maintain liaison with the voluntary health agencies in the area."

The Council on Specialty Medicine through the Chairman, Dr. Emmet F. Ferguson Jr., of Jacksonville, requested that each specialty present for publication a short discussion of the reasons for its recognition as a specialty group and the functions of its members. With this issue, The Journal presents the first of these discussions. Others will follow.

T.M.

Anesthesiology

Anesthesiology is the medical specialty, subject and study of the art and science of the relieving of pain safely during surgical procedures and at other times. It also encompasses the subjects of shock, depression of the central nervous system and ventilatory problems.

Anesthesiology deals with the preoperative evaluation of patients and contributes to the estimation of operative and anesthesia risk. The prevention and treatment of hypovolemic shock are dealt with more by anesthesiologists than any other specialists and make the estimation of this and related problems a proper matter for consul-

tation with or treatment by anesthesiologists.

Because of the considerable daily experience of anesthesiologists in the use of drugs that are depressants of the central nervous system and in the judgments on respiratory adequacy, the areas of depressant and other drug poisonings fall within the scope of anesthesiology. Many ventilatory problems also come within the framework of anesthesiology, such as respiratory depression in the newborn, upper and lower respiratory encroachments by disease or trauma and status asthmaticus.

With his experience in the use of local anesthetic agents and his knowledge of nervous pathways, the anesthesiologist finds many pain syndromes, causalgias and other dysfunctions of the autonomic nervous system referred to him for blockade both for diagnostic and therapeutic efforts. The administration of oxygen in various ways is likewise well known to him and frequently comes under

his observation.

In the operating room, where the anesthesiologist spends the major part of his professional life, he finds a responsibility to share in the teaching of students, registered nurses and house staff. This is usually as expansile as the individuals involved choose to make it.

The proper use of muscle relaxants as well as depressants of the central nervous system is routine to the anesthesiologist. This knowledge leads him occasionally into such areas as electroshock, tetanus and convulsive disorders

A common misconception of anesthesiology is that rapport and a true and adequate physician-patient relationship are not even attempted. The allaying of apprehension, the easing of operating room tensions and the bolstering of confidence of all persons concerned are very much a part of anesthesiology.

Not infrequently the dexterity of the anesthesiologist is called upon to accomplish procedures ranging from the dramatic endotracheal intubation of a nearly asphyxiated patient to the menial but perhaps on occasion frustrating

task of a spinal tap or even venipuncture.

Anesthesiology includes, at teaching levels, the experimental probings toward safer patient care under enlarging surgical horizons. New drugs, techniques and equipment accouterments are born and perfected in such teaching centers.

Anesthesiology incorporates a working knowledge of recovery rooms, intensive care units and kindred entities.

Among the many facets of medical practice which do not fall properly to the anesthesiologist is the determination of the imperativeness or propriety of a proposed surgical procedure. This is the surgeon's responsibility and prerogative.

Finally, anesthesiologists by virtue of their experiences in operating rooms, with staff physicians and hospital administrators are valuable to committees within and without hospitals touching or merging on these subjects.

Remember, whatever their individual defects, anesthesiologists will protect your homestead exemption.

JAMES D. BEESON, M.D. JACKSONVILLE

Dermatology

For more than 150 years the study of the skin has been a special field unto itself. Even extending back into the earliest records of human history, the skin has been the subject of much inquiry and speculation. It remained for Robert Willan of England to collect the substantial knowledge up to his day and publish, in 1808, his treatise "On Cutaneous Diseases." Since that time, dermatology as a specialty has continued to grow and ascend, at first in Europe, then in the United States. With the advent of World War II, it became apparent that diseases of the skin were a major factor of morbidity, in that approximately 20 per cent of all medical problems of the Armed Forces were dermatologic ones.

Because of expanding industrialization and the heightened exposure to a multitude of synthetic products and solvents, the loss of man hours due to occupational dermatitis runs enormously high. In addition, some 10 to 20 per cent of all patients seen by the general practitioner are known to have dermatologic disorders. It will be readily recognized, therefore, that medical students need effective dermatologic teaching so that they may be capable of diagnosing and treating common diseases of the

skin intelligently.

By virtue of his training, the dermatologist probably knows more about the skin and is more expert than his confreres regarding the detailed medical aspects of skin diseases. He thereby serves an important role. It is appalling to learn that in the absence of dermatologic consultation kerions (inflammatory fungus granulomas) have been excised as malignant tumors; syphilitic alopecia has been treated with scalp lotions; the mother of a child with morphea (localized scleroderma) has been informed that this disease would spread and cripple and eventually kill the child; a patient with discoid lupus erythematosus has been told that it would inevitably develop into a fatal disease. Unhappily, similar examples can be cited ad nauseam. There is logically, then, the need for specialists who are informed about the natural history of dermatologic diseases and the details of their prognosis and treatment

In order to achieve proficiency in dermatology, a good deal of training beyond the internship is required. Essential is a sound foundation in internal medicine. The accredited dermatologic program itself demands three years of study. This training is basic, and when the opportunity affords, dermatologists may undertake further work in special fields such as mycology, histopathology,

immunology, radiation therapy, or research.

Contrary to the outworn canard about incurable patients prated by generations of frustrated physicians, the percentage of satisfactory results of treatment of diseases of the skin by qualified specialists is probably higher than that achieved in any other branch of medicine. Incurable patients are unfortunately represented in all specialties, to the same extent as in dermatology. Today the perceptive comprehension of psychosomatic factors has inspired an improved understanding of the mechanism of resistance to treatment of many patients with chronic dermatoses.

The past 15 years have marked a golden era in fundamental dermatologic research in the United States. At 10 or more medical centers, among them the University of Miami, teams of outstanding investigators have pursued fruitfully a wide range of laboratory studies concerning the normal and abnormal skin. As a result there is emerging a revitalized dermatology, dynamically oriented toward the exciting discoveries of modern biochemistry, physiology, pharmacology, and other fields of scientific

investigation.

Clinical dermatology, as such, has no boundaries. It is closely connected with all the medical specialties. Lupus erythematosus, sarcoid, scleroderma, erythema nodosum were first identified and intensively studied by dermatologists. They are now the domain of all physicians who have a wide appreciation of disease and are concerned with the patient's total well-being. Cutaneous cancer has been treated by dermatologists since the earliest days of the specialty, and dermatologists have contributed importantly to the knowledge of precancerous lesions. The skin participates in many immunobiologic phenomena which have been investigated and clarified by dermatologists. In addition to manifesting its own diseases regulated by its own laws, the skin is a screen onto which physiologic and psychiatric disturbances are projected in fascinating profusion and variety. Dermatologists are interested not only in what severe skin disease does to the general physiology but also in what internal disease does to the skin.

Dermatology is on the advance, utilizing the achievements of all the specialties and basic sciences. In its development it will, in turn, continue to contribute to the enhancement of scientific and clinical knowledge, with the ultimate aim of elucidating the causes, biologic alterations, natural course and rational treatment of disease.

MORRIS WAISMAN, M.D. TAMPA

General Practice

General practice has been variously described, including treating the skin and its contents or doing everything to everybody. The general practitioner is said to be a doctor who knows less and less about more and more, while the specialist is one who knows more and more about less and less.

The American Academy of General Practice defines a general practitioner as follows: "A general practitioner is a legally qualified doctor of medicine who assumes total and continuing responsibility for the health care of his patient as a person and the family as a unit. In his capacity as family physician and medical adviser he may, however, devote particular attention to one or more special fields, recognizing at the same time the need for consulting with qualified specialists when the medical situation exceeds the capacities of his own training or experience."

The Board of the Academy recently adopted the following statement which succinctly outlines what it considers to be the *minimum* training for the *minimum* of hospital privileges for general practitioners:

"Functions for a general practitioner to be trained in and allowed to perform upon the completion of his training with a minimum of two years training past graduation from medical school:

A. Internal medicine and psychiatry

B. Pediatrics

C. GynecologyD. Surgery commensurate with demonstrated ability and training

E. Obstetrics

"Additional privileges would be based on training and

experience.
"In adopting these functions it should specifically be understood that the general practitioner must receive hospital privileges commensurate with the above."

Despite some so-called authoritative statements to the contrary, neither has the general practitioner lost his usefulness in the broad field of medical service nor are the majority of patients willing to abandon their dependence on or security in the attention and care of general practitioners. These facts are confirmed by unbiased surveys.

It has been estimated that the general practitioner handles 87 per cent of the ills of which patients complain. By providing continuity of medical supervision of the entire family, with an awareness of the environment, the heredity, and the psychological relationships of the components of the family, the general practitioner has the benefit of the over-all factors influencing a particular disease entity of the individual family members. Thus he can better treat and advise his patients—treating within the limits of his training and experience, advising consultation when indicated.

Rather than being an antagonist or in competition with specialists, general practitioners practice in symbiosis with them, handling the many common and moderately complicated conditions, and referring the unusual cases to the specialty-trained physicians and surgeons.

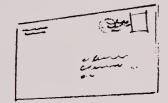
Preventive medicine, the regular and routine physical examinations, is one of the greater fields of service and competence of the general practitioner. Similarly, the administration of routine immunizations, the prescribing of formulas and diets for well babies, and the care of many pediatric conditions are within his province. In the field of obstetrics, the majority of deliveries are performed ably by the general practitioner trained in this branch. Most general practitioners are capable of performing varying amounts of minor surgery.

In the ever enlarging field of mental health, the general practitioner is the bulwark of the first line of defense, since it is to him that the greatest number of patients will bring their problems first. He can frequently institute early treatment that will prevent the evolution of full-

blown psychoses.

In general practice as in all medical practice, the conscientious physician does not attempt to handle cases for which he is not trained.

LEO M. WACHTEL, M.D. JACKSONVILLE



Letters

Dear Sir:

In the September issue of The Journal of the Florida Medical Association, you published a letter by W. E. Manry, Jr., M.D., editor of the Polk County Medical Association Bulletin, Lake Wales, in which he voiced his objection to the recommendations of the Florida Society of Pathologists that advertisements from lay laboratories not be accepted for The Journal of the Florida Medical Association. Doctor Manry said that he was pressured by pathologists to automatically exclude advertising by lay clinical laboratories from his journal and that the only reason given was that the A.S.C.P. believed it to be improper. Doctor Manry did not indicate whether any reasons were given as to why it is improper, nor did he indicate whether he made any inquiry to the American Society of Clinical Pathologists or the College of American Pathologists.

Physicians, attorneys, and other professional people do not advertise. By advertising we mean the paid ad which is designed to arouse a desire to patronize in the usual business sense. Why do physicians not advertise? The reasoning behind this must be based on the fact that such individuals have attained a degree of knowledge in a specialized field in which the primary motivation is somewhat different than in the businessman's field. This contrast between business and professional service is fairly obvious. Where a patient is confined to a convalescent home, the

patient or his family can quickly tell if the room is clean, the bed clothing changed, the food satisfactory, etc. If one buys a pair of glasses, it is immediately obvious whether or not the glasses are reasonably satisfactory. The same is true in the usual course of business transactions. On the other hand, the patient is generally not able to make a sound judgment as to the quality of a physician's or attorney's professional opinions and actions—specialized training is necessary.

The same is true in the professions of biochemistry, bacteriology, and medical technology. When a physician receives a report on a P.B.I., for example, does he know the qualifications of the professional individual who performed the service? Can he evaluate the quality of the work from the report?

Is he familiar with the quality control procedures used, if any? It is apparent the physician is in the same position as his patient when the patient receives the doctor's diagnosis and treatment.

The biochemist is a highly skilled professional individual and therefore must conduct himself on the same ethical plane comparable to other professions, particularly when he is performing work in the field of medicine. If the biochemist performs the same work as a pathologist in a particular specialized field, then he should also be expected to conduct himself in an ethical manner comparable to the pathologist or other professional individuals.

If professional people advertise, they would put themselves in the position of the businessman who is putting emphasis on volume and profit. Volume and profit motivations are essential for the growth of business; however, this is certainly not the motivating force of physicians and other professions, including medical technology, biochemistry, and bacteriology. It is the responsibility of each individual practicing his profession, whether it be medicine or some other profession, to impose upon himself standards of ethical conduct. Whether or not the individual belongs to an organization with punitive powers is irrelevant. Individual responsibility is essential for the highest standards of performance.

Doctor Manry draws a comparison between the convalescent centers and psychiatric facilities which advertise in the medical journals and also ethical optical laboratories. In all of these instances, the comparison is certainly not warranted, since the services of these various types of businesses are not comparable to the individual services of professional people such as physicians, biochemists, bacteriologists, and medical technologists. Their standards of ethics are entirely different with regard to forms of advertising and this is well known.

When the editor of a medical journal receives an advertisement from a professional individual, he is not in a position of evaluating that individual's services and should recognize the fact that the standards of ethical conduct of that particular profession should have prevented the individual from submitting the advertisement in the first place. This in no way interferes with the principle of free enterprise and "honest competition" as Doctor Manry calls it. There are well accepted methods for professional people to communicate with the individuals they would like to serve and offer their services. Professional individuals operating laboratories should restrict themselves to these ethical means of communication.

Sincerely yours,
DAVID K. DAVIS, M.D., PATHOLOGIST
ST. PETERSBURG

News

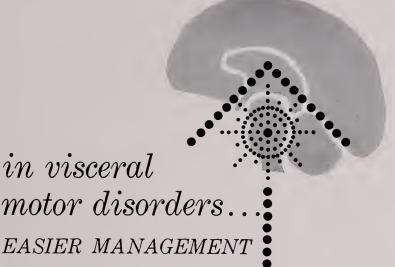
Dr. Bennett Sallman has been appointed Chairman of the Department of Microbiology at the University of Miami School of Medicine. A professor in the Department, Dr. Sallman had assumed the duties of acting chairman in 1961.

A Workshop in Teratology will be sponsored by the Commission on Drug Safety at the University of Florida in Gainesville on February 2-8, 1964 through a grant from the Pharmaceutical Manufacturers Association.

Dr. Donald W. Smith of Miami has been appointed a member of the Board of Directors of the Flying Physicians Association.

An International Symposium on "Anticoagulant Therapy in Ischemic Heart Disease will be held January 9-11, 1964 at the Fontainebleau Hotel, Miami Beach. It is sponsored by the Miami Heart Institute under the chairmanship of Dr. E. Sterling Nichol of Miami.

The annual meeting of the Southern Medical Association is being held in New Orleans on November 18-21. Dr. L. Washington Dowlen of Miami is currently serving as second vice president of the Association.



cant factor in dysfunction of gastrointestinal tone, motility and secretion, Pro- gastrointestinal tract. Banthīne with Phenobarbital provides the dual activity that leads to easier management of both the patient and his problem:

Pro-Banthine (propantheline broimpulses at visceral end organs, and

Phenobarbital to moderate emotional incitement centrally.

Pro-Banthīne with Phenobarbital is indicated when a mild to a moderate psy- 6. D. SEARLE & CO. chic element is a factor in: Peptic ulcer • Biliary dyskinesia • Pylorospasm • Intes-

PRO-BANTHĪNE® with Phenobarbital

Each tablet contains: propantheline bromide ... 15 mg. phenobarbital 15 mg. (Warning: May be habit forming)

When emotional disturbance is a signifi- tinal hypermotility • Spastic colon • Gastritis • Other dysfunctions of the

Dosage: One tablet four times a day.

Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action might occur with Pro-Banthine (brand of mide) to neutralize the effect of excitatory of propantheline bromide). It is contraindicated in the presence of glaucoma or severe cardiac disease. The usual precautions with regard to phenobarbital should be taken.

CHICAGO 80, ILLINOIS

Research in the Service of Medicine

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding

safety record -- in 25 years of use no report of an untoward reaction

> it should be used , with care on patients

has been received; however,



parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenal 0.25%; sodium carbonate as buffer. Camplete data with each 10cc vial. Therapy chart an request.



hatham) CHATHAM PHARMACEUTICALS, INC.

Newark 2, New Jersey

Distributed in Conoda by Austin Laborotories, Ltd. • Poris, Ontario

Dr. Warren W. Quillian of Coral Gables, President of the Florida Medical Association, was principal speaker at the October meeting of the Duval County Medical Society in Jacksonville.

Four special subjects related to cancer will be highlighted by speakers on the program of the fifth annual "cancer scrimmage" for physicians being held Saturday, November 30, in the Lecture Hall of the Otto Richter Library, University of Miami at Coral Gables.

Meetings

November

Florida Radiological Society, Fall Meeting, November 1-3, Far Horizons, Longboat Key, Sarasota

Seminar in Diagnosis of Cardiac Arrhythmias, November 1-4, Tampa General Hospital, Tampa

Fourth Annual Medical Seminar Cruise, November 23-30, M S Riviera from Fort Lauderdale, University of

Florida College of Medicine, Gainesville Florida State Surgical Division, International College of Surgeons, Fourth Annual Fall Meeting, November 29-30, University of Florida College of Medicine, Gaines-

American Fracture Association, 24th Annual Meeting, November 10-15, Hotel Americana, Bal Harbour, Miami Beach

Florida Pediatric Society, Fall Meeting, November 14-17, Grand Bahama Hotel, West End, Bahamas

December

American Medical Association, 17th Clinical Meeting, December 1-4, Memorial Coliseum, Portland, Ore.

Florida Obstetric and Gynecologic Society, Fall Meeting, December 6-8, Grand Bahama Hotel, West End, Rahamas

Florida Society of Ophthalmology and Otolaryngology, Dec. 6-8, Colony Beach Resort, Long Boat Key, Sarasota

Florida Urological Society, Dec. 6-7, Cherry Plaza Hotel, Orlando

January

Florida Medical Association Sixth Annual Conference of County Medical Society Presidents and Secretaries, Jan. 25-26, Robert Meyer Motor Inn, Orlando

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

GLENWOOD, FLORIDA MRS. A. H. DUVALL



STARTING TOMORROW MORNING this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule® Trademark brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 11/2 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' Spansule capsule taken in the morning.

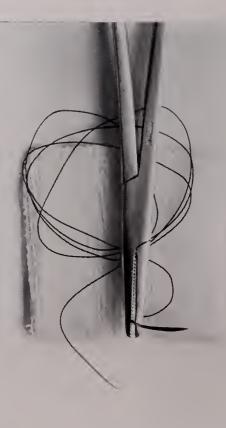
SIDE EFFECTS: Insomnía, excitability and increased

motor activity are infrequent and ordinarily mild CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories Prescribing information Jan. 1963



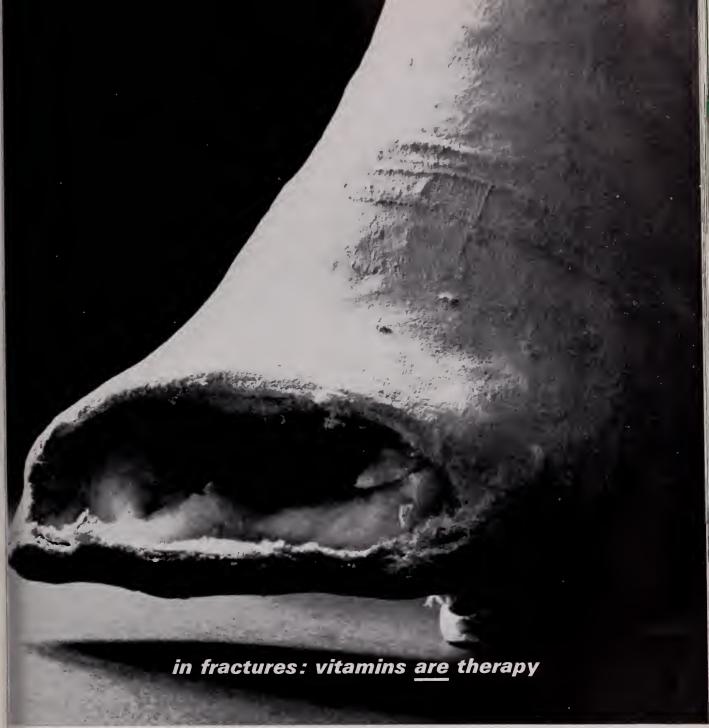


In trauma, whether it's sutures, plaster, splint or sling...

remember 'Empirin' Compound to relieve pain



Also: 'Empirin'® Compound with Codeine Phosphate* gr. $\frac{1}{8}$ -No. $\frac{1}{gr}$. $\frac{1}{4}$ -No. $\frac{2}{gr}$. $\frac{1}{2}$ -No. $\frac{3}{gr}$. $\frac{1}{1}$ -No. $\frac{4}{8}$ *Warning—may be habit forming



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery.

Each capsule contains: Vitamin B1 (Thiamine Mononitrate) ... 10 mg. / Vitamin B2 (Riboflavin) ... 10 mg. / Niacinamide ... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B₆ (Pyridoxine HCl)...2 mg. / Vitamin B₁₂ Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deliciencies. Supplied in decorative "reminder" jars of 30 and 100.



Cederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

Stress Formula Vitamins Lederle

CLASSIFIED

FOR RENT: Complete office. Ready to move into in the Doctors Building. \$110. per month including air-conditioning, heat, hot water and janitor service. Downtown location, abundance of free parking for patients. Contact S. J. Wilson, M.D., 309 N. E. River Drive, Fort Lauderdale, Fla.

WANTED: General Practitioner, Internist, Pediatrician, to join surgeon in new clinic. Exciting growth enterprise in finest Cape Canaveral location. Arrangements open. Write 69-484, P.O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN WANTED: For association in Hollywood, Fla. Must be Board qualified or certified. For information contact Medical Business Consultants, 1101 N.E. 79th St., Suite 205, Miami, Fla. Telephone PL 9-0230.

WANTED: Pediatrician, ENT, Internist and Dermatologist for new medical building ready Feb. 15. Adjacent to hospital in beautiful location on Gulf of Mexico. Fine practice opportunity. Write 69-510, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER: New professional office for rent Cocoa, Fla. 1,200 sq. ft. floor space. Designed for physician. Wired for X-ray. Nicely paneled personal office and waiting room. 5 examining rooms each equipped with wash basin. Laboratory. Central air-conditioning system with reverse cycle for central heat. Adjoining new upper class 30 unit furnished apartment complex. Ground floor corner location with exterior professional design. Ample parking. 3 separate entrances. Choice location in fastest growing county in U.S. For information call A. A. Annis, Newton 6-1872 or write P.O. Box 6, Cocoa, Fla.

MEDICAL OFFICE AVAILABLE: Unusual opportunity for GP or specialist in Miami Beach. Call Jefferson 1-1246 or contact: Dr. Leonard Sakrais, 1500 Bay Rd., Miami Beach, Florida.

RESIDENCE - PROFESSIONAL OFFICE, UNFURNISHED: For attractive Florida living and pleasant working with generous income tax considerations, this is the place. Centrally located; choice section; corner location. Five room office suite with lavatory; five large rooms in residence segment, 2 baths. Central air conditioning; radiant heating in tile floors throughout. Spacious attic storage. Office accommodates busy practice; courtyard affords ample parking. Separate large garage and air conditioned guest house with comfortable Florida room, bedroom, kitchen, bath. Carport. Entire property (3 city lots) is enclosed by wall and three wrought iron gates. Pool in large patio; artistic barbecue. Long sundeck overlooks pool, patio, and Japanese-like gardens; beautifully land-scaped for minimal maintenance. \$85,000 (two thirds cost); \$45,000 mortgage available. Write Meredith Campbell, 1501 South Miami Avenue, Miami, Florida.

WANTED: Pediatrician for association with two obstetricians. Office space, basic equipment and guaranteed income are available for an acceptable man. Write 69-551, P.O. Box 2411, Jacksonville, Fla.

PRACTICE FOR SALE: Excellent general practice and equipment, Fort Myers proper, established 17 years same location. Contact: Curtis R. House, M.D., 2203 McGregor Blvd., Fort Myers, Fla.

WANTED: Associate by busy general practitioner. Excellent remuneration to start with full partnership after one year. No investment necessary. Write 69-552, P. O. Box 2411, Jacksonville, Fla.

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis, fat accumulation, weight gain; thus appear to aggravate obesity in diabetics¹⁻⁵...serum "insulin" levels are often elevated in obese diabetics^{2,3,6}...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.^{1,3,7-9}

most effective in the obese diabetic

DB DB DB timed-disintegration capsules 50 mg

BRAND OF PHENFORMIN HCI



LOCUM TENENS: Experienced General Practitioner desires locum tenens for month of January. Has Florida license. Write 69-554, P.O. Box 2411, Jacksonville, Fla.

AVAILABLE: For \$90 enjoy professional suite of 4 rooms air-conditioned in Medical Arts Building, 503 W. Platt, Tampa. Phone 251-1600.

PEDIATRICIAN WANTED: Florida license. \$1000 minimum monthly guarantee first 6 months or 40% of income. Second 6 months 45% and full partnership after one year. Large income now. May be expected to increase considerably with complete coverage of vacation and days off. Write 69-547, P.O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN WANTED: For association in present two man partnership. East coast Florida town. Prefer FAAP or Board eligible. Write full particulars in first letter. Write 69-548, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER wanted for full time group practice in Central Florida in Fall of 1963. This is a large established practice in pleasant community. Please send resume to 69-543, P.O. 2411, Jacksonville, Fla.

WANTED: Nose and throat man, Obstetrician, Dermatologist, Internal Medicine. Arrangements open. Growing community. Phone John O. Rao, M.D. 847-2833, Kissimmee, Fla.

OFFICE SPACE FOR RENT: Medical suite, approximately 600 sq. ft. in separate consultation, two treatment and laboratory rooms. Share secretary and reception room. New professional building, excellent furnishings. Suitable for specialty or general practice. Clarence H. Schilt, M.D., 2161 McGregor Bldg., Ft. Myers, Fla.

RADIOLOGIST: Age 31, Florida license, military obligation completed, seeking position or association in radiotherapy or general radiology with therapy opportunity. Completing residency and available July 1964. Write 69-553, P.O. Box 2411, Jacksonville, Fla.

OPHTHALMOLOGIST WANTED: East Coast city, to associate in large established practice. Board certified or eligible. Write 69-555, P. O. Box 2411, Jacksonville.

FOR LEASE: Large, modern equipped doctor's office on West coast Florida. X-Ray, EKG, etc. Former doctor left after 5 years for residency in Radiology. Lease including equipment \$250 per mo. Write P. J. Palmisano, M.D., 1169 E. Northern Parkway, Baltimore 12, Md.

SURGEON: Desires relocation in solo or group in Florida. Have Florida license, ACS and Board qualified. Will do some general practice. Write full details first letter. Write 69-534, P.O. Box 2411, Jacksonville, Fla.

MIAMI'S NEWEST PRESTIGE BUILDING—MERIDIAN 17-OFFICE SPACE NOW RENTING. A symbol of leadership . . . striking lobby . . . carpeted, well-lighted corridors . . . sun-screen windows . . . ocean and bay views . . . high-speed Otis Autotronic elevators . . . Carrier central air-conditioning and heating . . . private parking. Just off Lincoln Road Mall, near convention hall . . . only 15 minutes from Miami Airport. Color brochure on request. Rental Office: 1688 Meridian Avenue at 17th St., Miami Beach, Fla. Phone JE 4-4757.

WANTED: General Practitioner for Clinic-Hospital. Salary open—plus bonus. Write 69-535, P.O. Box 2411, Jacksonville, Fla.



DBI and DBI-TD (phenformin HCI),

administered to ketoacidosis-resistant diabetics requiring hypoglycemic therapy: A. act to reduce high blood sugar without increasing fat synthesis or weight gain as insulin and sulfonylureas tend to do. B. do not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal insulin levels. C. favor reduction of weight towards normal.

Insulin is still the essential hypoglycemic agent for the ketoacidosisprone diabetic. However, in the ketoacidosis-resistant obese diabetic phenformin appears to be the hypoglycemic of choice to help avoid weight gain or reduce adiposity, a factor tending to make control more difficult and to increase the likelihood of complications.

Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grod-sky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophol, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

U.S. VITAMIN & PHARMACEUTICAL CORP.

800 SECOND AVENUE, NEW YORK 17, N.Y.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

- 1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.
- 2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.
- 3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness ("numbs the pain...not the patient").

- 4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.
- 5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma Compound



carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning — may be habit forming.)



winter coughs ahead... clear the tract with Robitussin[®]

ROBITUSSIN®

ROBITUSSIN® A-C

Robitussin with antihistamine and codeine.

Each 5 cc. tsp. contains:

Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10 mg.
(exempt narcotic)

Photo: N. & W. Engine No. 611, last of the famous "Class J" locomotives, on its final run between Roanoke, Va., and Williamson, W. Va., Oct. 26, 1959.



For the coughing patient who labors to remove tenacious mucus from his respiratory tract, Robitussin provides a remarkably potent expectorant action. It contains glyceryl guaiacolate which increases respiratory tract fluid (R.T.F.) almost 200% to "clear the tract" of coughinducing irritants. Increased R.T.F. also per-

mits more efficient action of bronchial and tracheal cilia to further enhance the evacuation of sputum, thus reducing cough frequency and helping the cough remove its cause.

After more than thirteen years and millions of prescriptions, no serious side effects have been reported from Robitussin. And patient acceptance has been outstanding.

A. H. ROBINS COMPANY, INC., Richmond 20, Virginia

This is the season Allbee® with C is made for!



When a good old-fashioned winter proves too much for your modern-day patients, it's a comfort to know about Allbee with C. Consider its simple, rational, economical formula when patients need therapeutic amounts of B and C vitamins during the "flu" and u.r.i. season. This is what Allbee with C is made of: Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine HCl (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

A. H. Robins, Co., Inc. Richmond 20, Va.

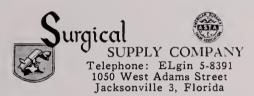
Proctologic Aid

PROCTO-REST is a simple device that provides a full measure of convenience in sigmoidoscopy procedures. It is designed to establish and maintain correct positioning of the patient. Its sturdy construction and formed padding provide comfort and induce relaxation.

Takes only seconds to unfold. Has locking bracket for complete safety. Can be used on any examining table.



Folds compactly for storage. Fits into the base of the examining table or a storage cupboard. Supplied in gray, white or brown upholstery.



BALLAST POINT MANOR

SANITARIUM

Care of Mild Mental Cases, Senile Disorders and Invalids Alcoholics Treated



5226 Nichols St. Telephone 831-4191

DON SAVAGE Owner and Manager

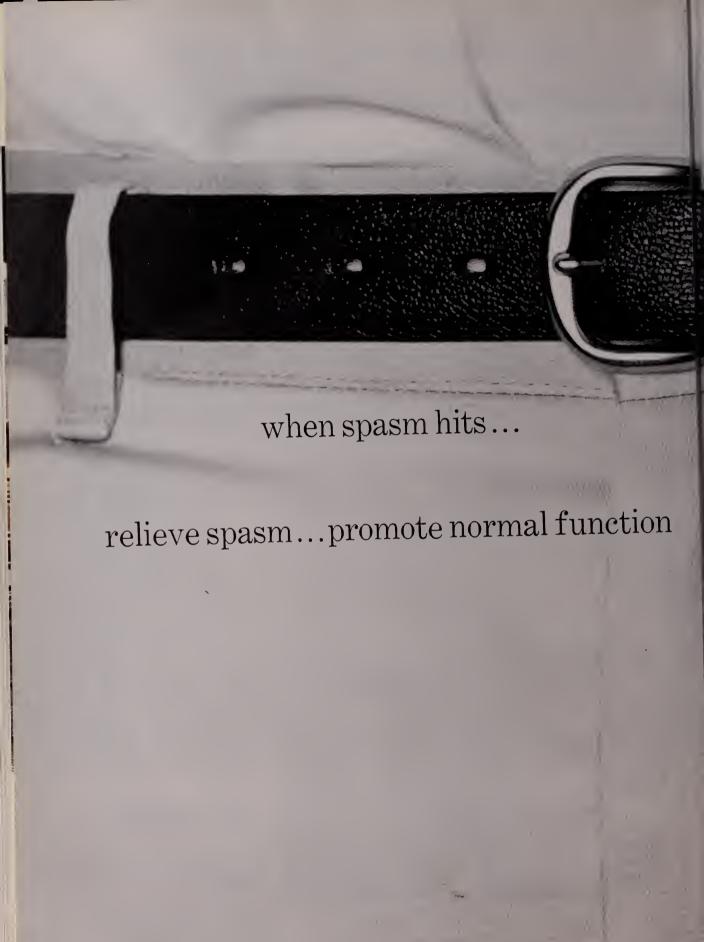
Aged adjudged cases will be accepted on either permanent or temporary basis.

Safety against fire — by Automatic Fire Sprinkling System.

Cyclone fence enclosure for recreation facilities, seventy-five by eighty-five feet.

Member of American Medical Assn. American Hospital Assn. Florida Hospital Assn.

> P. O. Box 13467 Tampa 11, Florida





${\it rew PATHILON}^*SEQUELS^*with Phenobarbital$

TRIDIHEXETHYL CHLORIDE Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride...75 mg.; Phenobarbital...45 mg.

ormulated for controlled release of the active igredients, for *sustained anticholinergic pro- ction* against spasm and pain in the G.I. tract, s well as *sustained phenobarbital action*.

liminates the necessity for numerous doses; attens out "peaks and valleys" in drug blood wels that can minimize effectiveness; and reases protective medication through the night. If the gastrointestinal tract (duodenal ulcer, testinal colic, ileitis, esophageal spasm, testinal spastic colon, alcohol-induced G.I. psets, gastric hypermotility) and anxiety

neurosis with G.I. symptoms. Should be used as an adjunct to other measures. Side Effects due to tridihexethyl chloride: dry mouth, blurring of vision, constipation. Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention. Supply: Bottles of 30 and 500.

Also available: PATHILON SEQUELS (without phenobarbital) Tridihexethyl chloride, 75 mg. Bottles of 30 and 500.



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, N.Y.





Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours - and provides these other advantages:

- 1. Especially suitable for maintenance therapy. Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.
- 2. Simpler dosage schedule. Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets - and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: 'Meprospan'-400 (meprobamate, sustained release) contains meprobamate 400 mg. 'Meprospan'-200 (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. Usual dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

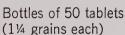
Meprospan-400 meprobamate 400 mg.

sustained release

WALLACE LABORATORIES / Cranbury, N.J.

HOW TO WIN FRIENDS...

New
Orange Flavored
Bayer Aspirin for Children
is sweet
all the way through,
so children
take it readily.
The GRIP-TIGHT CAP --on the bottle
helps keep them
from taking it
on their own.



NOW! NEW ORANGE FLAVOR!



GRIP-TIGHT CAP GAYER GENUINE

We will be pleased to send professional samples on request.

THE BAYER COMPANY

Division of Sterling Drug Inc. Dept. 112 1450 Broadway, New York 18, N.Y.

HCV CREME

 $3\% \quad Iodochlorhydroxyquin \\$

1% Hydrocortisone

Provides ANTIFUNGAL. ANTIBACTE-RIAL, ANTI-INFLAMMATORY AND AN-TIPRURITIC action in dermatitis.

GEVIZOL

Each 5 cc. tspfl or tablet provides 100 mg. Pentylenetetrazol, 50 mg. Nicotinic acid. GEVIZOL is indicated in the treatment of the mentally confused, emotionally unstable, apathetic aged and aging patient. For the patient complaining of dizziness or fogginess. Reactivates the inactivated.

QUALITY SARON ECONOMY
PHARMACAL
CORPORATION

St. Petersburg

Florida

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



JACKSONVILLE 4539 Beach Blvd. Telephone FL 9-2191

ORLANDO

1511 Sligh Blvd. Telephone GA 5-3537

BRAWNER HOSPITAL. INC.

(Established 1910) 2932 South Atlanta Road, Smyrna, Georgia

FOR THE TREATMENT OF PSYCHIATRIC ILLNESSES
AND PROBLEMS OF ADDICTION
MODERN FACILITIES

JAS. N. BRAWNER, JR., M.D. Medical Director

ALOYSIUS I. MILLER, M.D. MARK A. GOULD, M.D.

Phone HEmlock 5-4486



P. L. DODGE MEMORIAL HOSPITAL

formerly

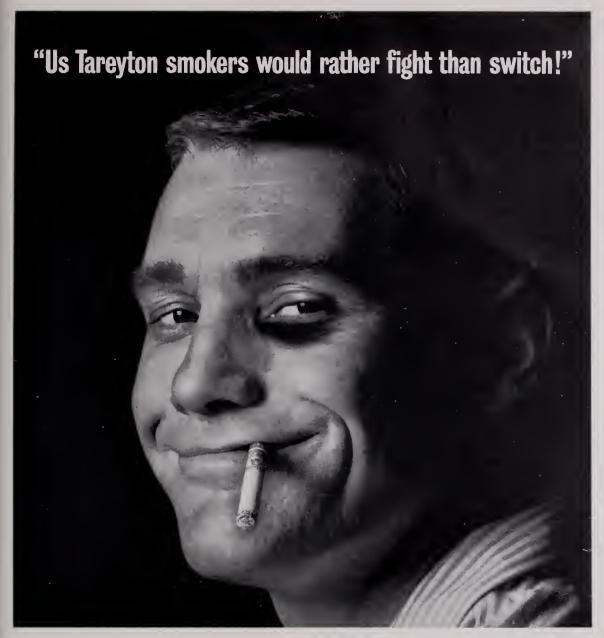
MIAMI MEDICAL CENTER

M. G. ISAACSON, M.D. Medical Director and President

1861 N.W. South River Drive Phone 379-1448

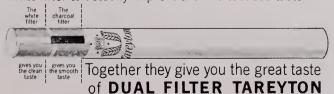
A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including — Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities.

Information on request
Member NAPPH and American Psychiatric Assn.



Join the Unswitchables and enjoy the great taste that inspires their aggressive loyalty.

Tareyton, of course, is famous for fine tobacco. Now see how the Activated Charcoal filter works with the white filter to actually improve the fine tobacco taste:



Product of The American Tobacco Company - Tobacco is our middle name @ 1 t. co.



A Hospital Using the Modern Concepts of Intensive Psychiatric Treatment Owned and Operated by the **Anclote Manor Foundation** A Non-Profit Organization ANCLOTE MANOR

SAMUEL G. HIBBS, M.D., F.A.P.A. President of the Board

Chief Consultant in Psychiatry

MEDICAL DIRECTOR Loront Forizs, M.D.

CLINICAL DIRECTOR
Walter H. Wellborn, Jr., M.D.

DIRECTOR OF TRAINING Theodore H. Gogliono, M.D.

STAFF PSYCHIATRISTS Robert G. Zeitler, M.D. Richord L. Meadows, M.D. Chos. J. Soporito, M.D.

ADMINISTRATOR
Fred P. Ryder, M.H.A.



The hospitol is ariented for Individual Psychotherapy, Group Psychotherapy, Therapeutic Community, all Somotic Therapies. The large staff is trained for Teom Appraach. Recreation by prescription.

Consultants in Psychiatry Walter H. Bailey, M.D., F.A.P.A. Arturo Gonzalez, M.D. Saul C. Holtzman, M.D. Alfred D. Koenig, M.D. Martha W. MacDonald, M.D. Roger E. Phillips, M.D. Zack Russ, Jr., M.D., F.A.P.A. Peter J. Spoto, M.D. Robert G. Steele, M.D. Samuel G. Warson, M.D., F.A.P.A.

Member National Association of Private Psychiatric Hospitals, American Hospital Association, Florido Hospital Association. Approved by American Psychiatric Association, Accredited by Joint Commission on Accreditation of Hospitals.

Located at TARPON SPRINGS, Florida — Phone: 937-4211



from confusion and apathy ...

... to Clarity and Interest Cerebro-Nici

A safe effective cerebral stimulant and vasodilator for your forgetful aging patient. On Cerebro-Nicin therapy, your patient shows improvement in social activity and relationships, and greater concern with personal appearance.

FORMULA:

P12 (Pentamethylene	
Tetrazole)	mg
Nicotinic Acid100	mg
Niacinamide 5	mg
Vitamin C	mg
Thiamine HCl 25	mg
Riboflavin 2	mg
Pyridoxine 3	
1-Glutamic Acid 50	mg

INDICATIONS: Apathy, dizzy spells, mild behavior disorders, mental confusion, functional memory defects.

AVERAGE DOSE: One capsule three times daily

AVAILABLE: Bottles of 100 and 500 capsules.

CAUTION: Most persons experience a flushing and tingling sensation after taking a higher potency niacincontaining compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause for discontinuance of the drug if the patient is forewarned to expect the reaction.

WARNING: Contraindicated in the presence of epilepsy.



Write for samples and literature... THE BROWN PHARMACEUTICAL COMPANY 2500 West Sixth Street, Los Angeles 57, California



for fast and long-lasting cough control

HYCOMINE SYRUP

Each teaspoonful (5 cc.) contains: Hycodan®

in a highly palatable, cherry-flavored vehicle (methylparaben 0.13% and propylparaben 0.02% as preservatives)

INDICATIONS: For both productive and nonproductive cough. For relief of symptoms in tracheitis, bronchitis, pneumonia, pharyngitis, bronchial asthma, pertussis, and allied conditions; cough

associated with allergy; in general, whenever cough medication is indicated.

posage: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U.S. Pat. 2,630,400.

caution: Should be used with caution in patients with known idiosyncrasies to phenylephrine HCl and in patients with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. May be habit-forming.



Literature on request

ENDO LABORATORIES Richmond Hill 18, New York

BELONGS IN EVERY PRACTICE

it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy.

Outstanding record of safety: Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it "belongs in every practice."

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress—and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: Indications: Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. Side Effects: Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. Complete product information available to physicians on request.

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d. SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.



The insomniac



The tense, nervous patient



The heart-disease patient



The surgical patient



he girl with dermatosis



Tension headache



The woman in menopause



Anxious depression



Premenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of meprobamate

Miltown



The G.I. patient



WALLACE LABORATORIES Cranbury, N. J.

Look into her eyes...She needs iron, too

PANTRINSIC-C

with Cobalt, Vitamin C and Hesperidin

NON-CONSTIPATING • NO G.I. UPSET • NO DIARRHEA

Ideally suited for pregnant patients

Each Two PANTRINSIC-C, round, pink tablets S.C. contain:

Ferrous Fumarate
Hesperidin
Ascorbic Acid
Cobalt Chloride10 mg.
Stomach Substance
Whole Liver
Thiamine HCI5 mg.
Vitamin R.12 5 mcg

Indications: For iron deficiency and anemias associated with blood loss.
• Malnutrition. • Pregnancy, etc.

Dose: Just two tablets daily. Available: In bottles of 100 and 500 tablets.



Write for samples and literature...

THE BROWN PHARMACEUTICAL COMPANY
2500 West Sixth Street, Los Angeles 57, California





Out-Patient Clinic and Offices

James A. Becton, M.D.

James Keen Ward, M.D.

P. O. Box 2896, Woodlawn Station, Birmingham 6, Ala. Phone WO 1-1151 and WO 1-1152

why does 150 mg.



do more than 250 mg.



of other tetracyclines?

Because it has up to $3\frac{1}{2}$ times the *in vitro* antibacterial activity'...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained *in vivo* activity with as much as 2 days' extra activity.

DEMETHYLCHLORTETRACYCLINE HCI

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. Side Effects typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCI. Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative in vitro Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. Amer. J. Med. Sci. 243:296 (Mar.) 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



TUCKER HOSPITAL, INC.

212 West Franklin Street RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological patients. Hospital and out-patient services.

(Organic diseases of the nervous system, psychoneuroses, psychosomatic disorders, mood disturbances, social adjustment problems, involutional reactions and selective psychotic and alcoholic problems.)

Dr. James Asa Shield Dr. George S. Fultz. Jr. DR. WEIR M. TUCKER DR. W. FREDERICK YOUNG

APPALACHIAN HALL

ASHEVILLE

Established 1916

NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en

Wm. Ray Griffin Jr., M.D. Robert A. Griffin, M.D. Mark A. Griffin Sr., M.D. Mark A. Griffin Jr., M.D.

For rates and further information write Appalachian Hall, Asheville, N. C.

OBETRO

for medical management of obesity

OBETROL incorporates the desired action of amphetamines with fewer side reactions reported.

MINIMAL SIDE EFFECTS

"In the cooperative patient, OBETROL was markedly beneficial in producing the desirable weight loss with minimal side effects, even in the case of a high percentage of patients with cardiovascular and other chronic ailments which normally make use of other amphetamines undesirable because of side effects".

WEIGHT REDUCTION EFFECTIVE IN DIFFICULT CASES

"With a daily divided dosage of 30 milligrams of OBETROL we were able to obtain appetite depression without nervous restlessness or insomnia ...

EFFECTIVE WHERE OTHER AMPHETAMINES FAIL

Twenty six patients who previously had been unable to use other amphetamines in any dosage sufficient to maintain the anorectic effect, responded favorably on this medication. 1,3

Contraindications: OBETROL is relatively contraindicated in hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases, anxiety and hyperexcitability. Habituation may occur with prolonged use. As in the case of all amphetamines, caution should be used in treating patients with these

Each OBETROL-10 tablet contains:

Methamphetamine Saccharate	.2.5 mgm.
Methamphetamine Hydrochloride	2.5 mgm.
Amphetamine Sulfate	.2.5 mgm.
Dextroamphetamine Sulfate	2.5 mgm.
(ORFTROI -20 tablets contain twice this notency	

Pat.# 2748052.

OBETROL PHARMACEUTICALS

382 Schenck Avenue, Brooklyn 7, N.Y.

¹ Simon. F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, 12:32-37, Jan. 1961.

² Plotz, M.: Modern Management of Obesity, J.A.M.A. 170:1513-1515 (July 25) 1959.

³ Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.



REQUEST SAMPLES AND LITERATURE

OBET	ROL PHARI	MACEUTICA	LS		
382 S	chenck Ave	nue • Brook	dyn 7, N. Y.		
Dr	· · · · · · · · · · · · · · ·	•••••		• < - • • • • • • • • • • • • • • • • •	
Addre	ess			•••••	
City				State	



CONFIDENCE

and well placed too!

The ophthalmologist knows that when he recommends a Guild optician, the service and quality which are a Guild tradition help to make his patient satisfied. He has confidence that his Guild optician will get the job done right.



Guild of Prescription Opticians of Florida

A special margarine for the atherosclerosis diet

The latest report* in the JAMA on atherosclerosis diets states, "...it appears logical to attempt to reduce high concentrations of cholesterol and other serum lipids as an experimental therapeutic procedure."

Since this report recognizes table spreads as an important source of dietary fat, we believe that it is in your professional interest to know about the fatty-acid composition of Mrs. Filbert's Corn Oil Margarine.

Mrs. Filbert's Corn Oil Margarine is a special margarine** made from 100% corn oil, over 50% of which retains its liquid characteristics.

Because of its high linoleic content, its ratio of polyunsaturates to saturates is about 1.7 to 1... and equals the highest level available today in *any* corn oil margarine.

Of the total fatty acid content, 28% is cis-cis linoleic acid.

Moreover, when you recommend Mrs. Filbert's Corn Oil Margarine, your patient is assured of receiving unmatched taste and flavor satisfaction—an important consideration in promoting adherence to any therapeutic regimen.

*AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).

**AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

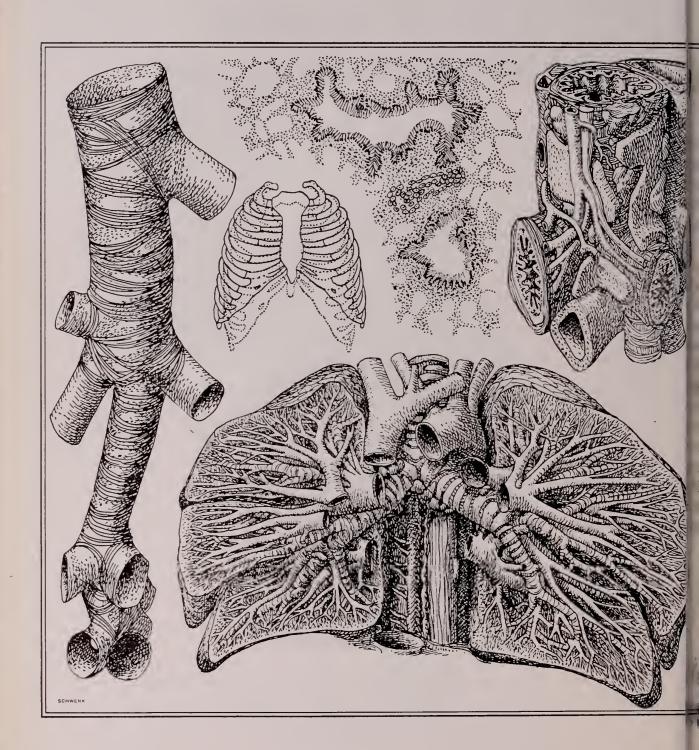


Made from 100% corn oil with liquid corn oil as its major ingredient

For additional information-including detailed listings of component characteristics-please write to us.

J. H. FILBERT, Inc.

BALTIMORE 29, MARYLAND



Air Rights

Vith ARISTOCORT Triamcinolone, many sthmatic patients obtain early gratifying lief of wheezing, dyspnea and spasmodic bughing. And maintenance dosage in many uses can be surprisingly low - often as little a single 2 mg. tablet per day. Yet it prodes this symptomatic control—which may table many patients to continue their cusmary livelihoods or regular household tivities—with only minimal interference ithothermetabolic functions. In this respect, RISTOCORT Triamcinolone is distinished compared with other corticosteroids, d and new. Typical steroid problems of dium retention and edema, euphoria, or racious appetite and excessive weight gain rely occur.

RISTOCORT Triamcinolone is indicated hen anti-inflammatory, anti-allergic action glucocorticoids is desired. SIDE EFFECTS of glucocorticoids generally: Cushingoid effects, hirsutism, leucopenia, purpura, vertigo, fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

PRECAUTIONS: ARISTOCORT Triamcinolone should be used with extreme caution in viral infection, particularly herpes simplex and chicken pox, in tubercular or fungal infection, in active peptic ulcer, acute glomerular nephritis or myasthenia gravis. FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup—2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

Aristocort Triamcinolone

laximum steroid benefits with minimum steroid penalty



LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.

Supplied: Bottles of 50 tablets.

CML-9646

Miltrate[®]

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / Cranbury, N. J.

A COMPLETE BUSINESS SERVICE

1 Managemen

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Avenue, N. E. St. Petersburg, Florida Phone 862-6903



314B John Ringling Blvd Sarasota, Florida Phone 388-1604

> Box 514 Miami 62, Florida Phone 945-4055

Affiliates of Black & Skaggs Associates Battle Creek, Michigan

² _J

Convention Press

218 W. CHURCH ST.

JACKSONVILLE, FLORIDA

QUALITY
BOOK PRINTING
PUBLICATIONS
BROCHURES

WHATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine quality work—and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

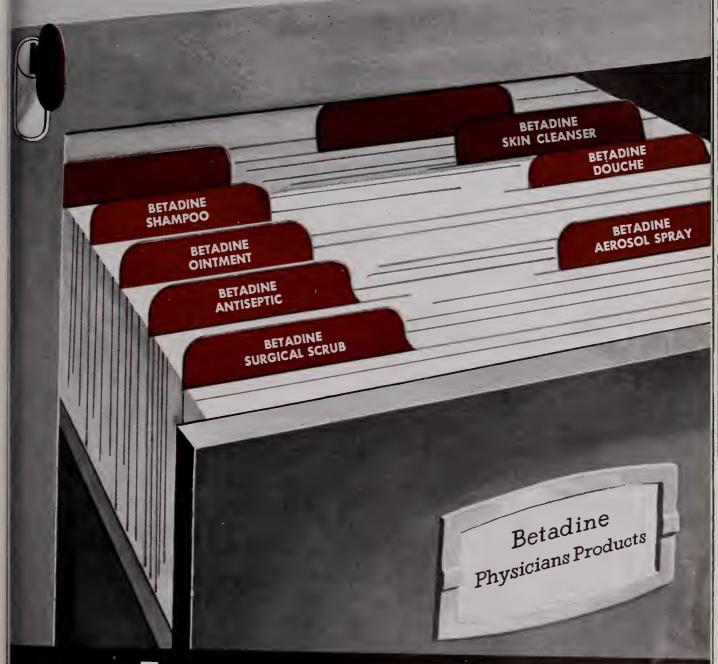
Betadine Povidone-lodine **Products**

unlock a wide range of usefulness

Betadine Products, in all seven dosage forms, contain povidone-iodine, a complex of polyvinylpyrrolidone and iodine, providing all the germicidal properties of elemental iodine . . . yet Betadine (povidone-iodine) is nonirritating, nonsensitizing, and nontoxic to skin or mucosa.

Betadine Products are effective in preventing and treating a variety of infections frequently encountered in the practice of otolaryngology, orthopedics and orthopedic surgery, obstetrics and gynecology, oral surgery, pediatrics, surgery and dermatology.

The clinical results reported under various conditions of use make Betadine (povidoneiodine) preparations valuable adjuncts both in the hospital and in private practice. Literature available upon request.





Specialized Service

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

11:13

MEDICAL PROPERTY COMPANY

BORTE WAYNE TUDIANA

Professional Protection Exclusively since 1899

MIAMI OFFICE: H. Maurice McHenry, Rep. 149 Na thwest 106th Street, Miami Shores Tel. Flaza 4-2703

NEW Design ... Appearance ... Versatility



Burdick EK-III Dual-Speed Electrocardiograph

The all-new Dual-Speed EK-III sets a new standard in high fidelity electrocardiography for recording the fine details of rapid small deflections. With its sensitive recording system the dual-speed paper drive with 50 mm. per second speed to enlarge the horizontal dimensions of heart complexes becomes highly important. Switch from standard 25 mm. to 50 mm. and back again with no transitional lag.

Special Features:

Simplified top-loading paper drive, single 4-position Amplifier/Record switch, convenient ground indicator, all-new single-tube stylus, jacks for cardioscope and D.C. Input connections, rapid lead selection, standard 50 mm. records. modern, clean design. Without sacrificing quality or utility, the EK-III unit is compact and weighs only 22½ pounds. Call or write us for full details; and if you wish we will be glad to demonstrate the EK-III in your office.

Anderson Surgical Supply Co.

ESTABLISHED 1916

Phone CHerry 1-9589 1616 N. Orange Ave. Orlando Phone 896-3107 556 9th St. S. St. Petersburg

Phone 229-8504 Morgan at Platt Tampa Phone 376-8253 729 S.W. 4th Ave. Gainesville



"The G-I tract is the barometer of the mind"



'The G-1 tract is the barometer of the mind

Each scored white tablet contains: 1/4 gr. Phenobarbital; 0.0072 mg. Hyoscine Hydrobromide; 0.024 mg. Atropine Sulfate; and 0.128 mg. Hyoscyamine Hydrobromide. BELBARB NO. 2-Same as Belbarb but with 1/2 gr. Phenobarbital, BELBARB ELIXIR—Each 5 ml, is equivalent to one Belbarb tablet.

Belbarb soothes the agitated mind and calms G-I spasm through the central effect of phenobarbital and the synergistic action of belladonna alkaloids on the G-I tract.

Indications: Belbarb is of particular value in conditions associated with visceral smooth muscle spasm and tension states, such as anxiety reactions, nervous tension, visceral spasm, irritable bowel syndrome, urinary tract spasm, peptic ulcer and hypertension.

Dose: TABLETS: 1 tablet q.i.d. 1/2 hour before meals and at bedtime, or as directed by physician. ELIXIR: Adults: 1 teaspoon q.i.d. Children 3-12 years: $\frac{1}{4}$ to 1 teaspoon q.i.d.

Warning: May be habit forming. Caution: Do not use in patients with glaucoma or in elderly patients with prostatic hypertrophy.

Send for samples and literature.

CHARLES C. HASKELL & COMPANY, Richmond, Virginia

Division of ARNAR-STONE LABORATORIES, INC.

FLORIDA MEDICAL ASSOCIATION

735 Riverside Ave., P. O. Box 2411

Jacksonville 3, Florida

Officers

WARREN W. QUILLIAN, M.D., President	Coral Gable.
SAMUEL M. DAY, M.D., President-Elect	
H. PHILLIP HAMPTON, M.D., Vice President	
EUGENE G. PEEK JR., M.D., Speaker of the House	Ocala
FRANKLIN J. EVANS, M.D., Vice Speaker	
FLOYD K. HURT, M.D., Secretary-Treasurer	Jacksonville
ROBERT E. ZELLNER, M.D., Immediate Past President	Orlando
W. HAROLD PARHAM, Executive Director	Jacksonville

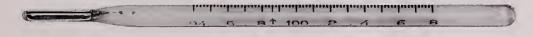
Councils

THOMAS C. KENASTON SR., M.D., Chairman, Council on Allied Professions and Vocations	
JERE W. ANNIS, M.D., Chairman, Judicial Council	Lakeland
H. PHILLIP HAMPTON, M.D., Chairman, Council on Legislation and Public Agencies	Tampa
BURNS A. DOBBINS JR., M.D., Chairman, Council on Medical Economics	Fort Lauderdale
HUGH A. CARITHERS JR., M.D., Chairman, Council on Medical Education and Hospitals	Jacksonville
CHARLES R. SIAS, M.D., Chairman, Council on Medical Services	
THAD MOSELEY, M.D., Chairman, Scientific Council	Jacksonville
WALTER C. PAYNE SR., M.D., Chairman, Council on Special Activities	Pensacola
EMMET F. FERGUSON JR., M.D., Chairman, Council on Specialty Medicine	Jacksonville
MASON ROMAINE III, M.D., Chairman, Council on Voluntary Health Agencies	Jacksonville

INDEX TO ADVERTISERS

American Tobacco Co	397 • Lederle Laboratories 351, 387, 392, 393, 403,
• Ames Co., Inc. Third (400 400
• Anclote Manor	254
Anderson Surgical Supply Co	2 35 1's 1 D starting Cs 412
Appalachian Hall	206
• Arnar-Stone Laboratories	- 01 (1 D)
Ballast Point Manor	- Davis & Co Second Cover 330
Brawner Hospital, Inc.	a Dharisiana Duaduata Co. Inc.
Brown Pharmaceutical Co	a D. J. D. J. Mannanial Hamital
Burroughs Wellcome & Co	2 DM - 6 Florida 410
• Chatham Pharmaceuticals, Inc.	2000
• Convention Press	Produ Course
Dorsey Laboratories	252
Duvall Home	206
• Endo Laboratories	283
• J. H. Filbert, Inc.	205
• Geigy Pharmaceuticals 347, 348, 349	201
• Glenbrook Laboratories	200
Guild of Prescription Opticians	AVI C 124 in P Discussional Comp 388 380
Hart Laboratories	410
Hill Crest Sanitarium	

one answer...three minutes



COMBISTIX — Dip this end

three answers

...ten seconds



combistix

urine protein • glucose • pH

BASIC COMBINATION TEST FOR BEDSIDE AND OFFICE

... faster than taking temperature. Detects glucosuria (as in diabetes), proteinuria (as in renal disorder), abnormal pH (as in calcinosis or GU infection). For routine screening of all patients. Combistix—basic as the stethoscope.

AMES products are available through your regular supplier. 30263



Library
New York Academy of Medicine
2 East 103rd St
New York 29 N Y J 12-63

anxie anxiety anxiety anxiety anxiety anxiety anxiety anxiety anxiety

anxiety reduced to its proper perspective

(chlordiazepoxide HC)
the successor
to the tranquilizers



In prescribing: Dosage—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Gerial patients: 5 mg b.i.d. to q.i.d. Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularity nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures until maintenance dosage is established. Though compatible with most drugs, use care in continuous procedures and continuous procedu

December, 1963

The JOURNAL

of the Florida Medical Association

FOUR AND ENGINEES IN BURNS

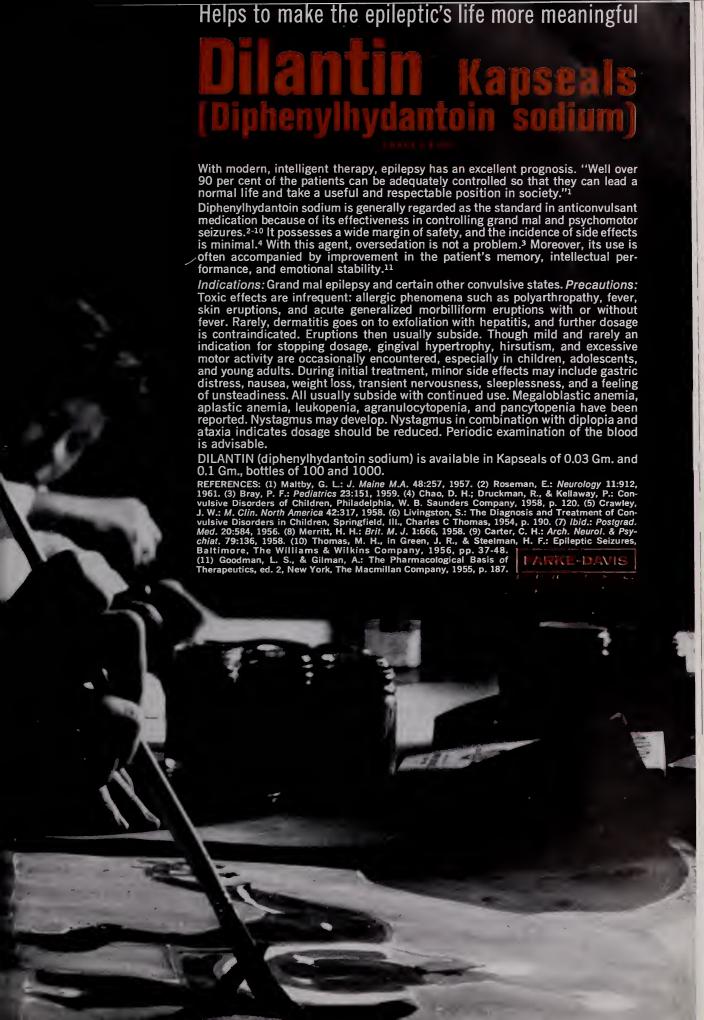
LEGITOPE MADE APPROPRIES IN BURNS

LABORO A OF THE INNER CANTHUS

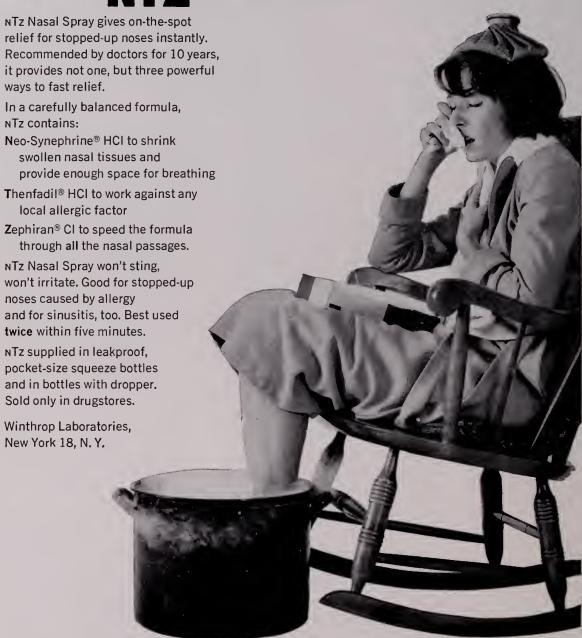
VALUE LEGITOPE NEW BORN







Colds haven't changed—but relief has with NTZ NASAL SPRAY





NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

The JOURNAL of the Florida Medical Association

Volume 50, Number 6, December 1963

THIS ISSUE

Fluids and Floatrolyton in Pours I Fundamials Family

THAD	MOSELEY,	M.D.
	Editor	

SHALER RICHARDSON, M.D. Editor Emeritus

Assistant Editors

CHARLES K. DONEGAN, M.D. FRANZ H. STEWART, M.D. JOHN M. PACKARD, M.D.

THOMAS R. JARVIS
Managing Editor

Louise Rader Assistant Managing Editor

EDITH B. HILL Editorial Consultant

Published monthly at Jacksonville, Florida. Price \$7.00 a year: single numbers, 70 cents. Address Journal of Florida Medical Association, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, Fla. Telephone EL 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Fluids and Electrolytes in Burns, J. Frederick Eagle, M.D.	433
Electrocardiographogenic Suicide, Henry J. L. Marriott, M.D.	440
Carcinoma of the Inner Canthus and Lacrimal Apparatus, Richard T. Farrior, M.D.	443
Varicella in the Newborn, David Multach, M.D. and Harry Kaufman, M.D.	448

Editorials

Articles

451
452
452
453

Features

President's Page	450
Letters	455
Association Meetings	456
	457
News	460
	464
Schedule of Meetings	487
County Medical Societies of Florida	488
Florida Medical Association Officers, Councils and Committees	489

This Journal is not responsible for the opinions and statements of its contributors. Owned and published by the Florida Medical Association.

cut Rx writing by 2/3 in colds, flu or grippe

NAME

ADDRESS

Ŗ

No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound...to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC 'EMPRAZIL-C'TABLETS

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	
Aspirin	200 mg.
Caffeine	•
*Mamina may be beli	formalma

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. Caution:

While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. Supplied: Bottles of 100 tablets.

Also available without codeine as 'EMPRAZIL'® TABLETS

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO (U.S.A.) INC.
Tuckahoe, N. Y.



READY JANUARY FROM SAUNDERS

A New Book! ATOMIC ENERGY ENCYCLOPEDIA IN THE LIFE SCIENCES

Edited by C.W. Shilling

Covers Applications and Effects of Atomic Energy in the Fields of Medicine, Biology, and Agriculture. Every Item Verified by Experts of the U.S. Atomic Energy Comm.

This is the information you'll find in this authoritative new information source: the effects of atomic radiation on living material; the uses of radiation and radioisotopes in medicine, agriculture and biology; scores of other peaceful uses of atomic energy. Topics range from treatment of cardiac disease with radioactive isotope iodine-131 to methods of radioactive waste disposal. More than 1200 alphabetically-arranged entries give you precise information on topics with wide application to clinical practice and research as well as on topics of general, scientific, educational and historic interest.

Dr. Shilling and his distinguished contributors have combined the features of a dictionary with those of an encyclopedia. You'll find definitions for hundreds of technical terms (absorption coefficient—acute radiation syndrome—cascade shower—Cerenkov radiation—mev—phantom—strontium unit—zeuto—neutron therapy—etc.) as well as articles of a page or more on such subjects as Recovery from Irradiution—Treatment of Radiation Illness—Blast Biological Damage—Radioactive Dosimetry—etc.

More than 260 helpful illustrations portray a diversity of topics: Example of radioactive contamination of the food chain—Cutaway drawing of a medical research reactor—Types of cell damage associated with irradiation—Schematic representation of the optical systems of the light and electron microscopes—Typical device for linear scunning of the entire body—etc.

In addition—98 tables list such information as: Colloidal and Large Particle Radioisotopes for Medical Uses—Gastrointestinal Absorption of Radioisotopes—Maximum Permissible Total Body Burdens for Four Radionuclides—etc.

Here is a volume you will turn to for precise answers to specific queries, as well as for fascinating browsing in rare leisure moments.

Editor and Major Contributor, Charles Wesley Shilling, M.D., D.Sc., Consultant to the United States Atomic Energy Commission; Deputy Director, Division of Biology and Medicine, USAEC, 1955-60. With the Assistance of Miriam Teed Shilling, M.A. Prepared under the auspices of the Division of Technical Information, USAEC, 474 pages, 7½" x 10½", with 268 illustrations, 98 tables About \$10.50.

A New Book! Gellis and Kagan's CURRENT PEDIATRIC THERAPY

Specific Details of Over 300 Treatments
Tailored to the Special Needs of Young Patients

A New Biennial Volume! This uniquely helpful Current Pediatric Therapy Volume brings you the same type of specific therapeutic recommendations that users of Current Therapy have enjoyed for some 15 years—but keyed directly to the treatment needs of children. Dr. Sydney S. Gellis and Dr. Benjamin M. Kagan have edited this new work, which will be revised every two years. Contributions by over 200 leading authorities pinpoint therapeutic details for more than 300 diseases—from Kwashiorkor and Protein Deficiency to Infantile Cortical Hyperostosis.

All discussions are approached from the pediatric point of view, with dosages, diets, prescriptions, etc., written for infants and children, and broken down, where necessary, into age or weight groups. You will find specific advice on: selection of proper antimicrobial agents for various types of pneumonia; use of methicillin and oxacillin in staphylococcic empyema; new dosage schedule for digitalis preparations administered to infants; detailed instructions for steroid therapy in leukemia; etc.

Whether you need a diet for a phenylkctonuric child, help on deciding the proper dosage of antiepileptic medication, or late information on immunization schedules, you'll find it spelled out in *Current Pediatric Therapy*.

A Biennial Volume. By 248 Leading Authorities. Edited by SYDNEY S. GELLIS, M.D., Professor of Pediatrics and Chairman of the Department of Pediatrics, Boston University School of Medicine; Director of Pediatrics, Boston City Hospital; and BENJAHIN M. KAGAN, M.D., Director, Department of Pediatrics, Cedars of Lehanon Hospital, Los Angeles; Clinical Professor of Pediatrics, University of California, Los Angeles, About 815 pages, 71/8" x 101/2", About \$16.00.

New—Ready January,1964!

To Order Mail Coupon Below!

W. B. SAUNDERS COMPANY West Washington Square, Philadelphia 5, Pa.
Please send when ready and bill me: Atomic Energy EncyclopediaAbout \$10.50 Current Pediatric TherapyAbout \$16.00
Name
Address SJG 12-63

A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

THE FIRST OBJECTIVE IN RELIEVING SINUS HEADACHE IS A PATENT PATIENT

The second, of course, is relieving the headache. Headache gone, sinus clear. The patent patient may not know it, but his sinus headache disappeared because in addition to analgesia, the tablet he took also relieved congestion. That's how Ursinus works.

Each Inlay-Tab® contains the completely soluble analgesic Calurin® (brand of calcium carbaspirin) equivalent to 300 mg. aspirin, plus the time-tested decongestant Triaminic® 50 mg. (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.). Use with caution in presence of hypertension, heart disease, diabetes, or thyrotoxicosis. If drowsiness occurs, patient should not engage in activities requiring maximum alertness. Usual dose is one Inlay-Tab four times a day. HEADACHE GONE, SINUS CLEAR.

HAVE YOU TRIED

URSINUS YET?

DORSEY LABORATORIES • a division of The Wander Company • LINCOLN, NEBRASKA

425

"They keep saying I'm sloppy!"



Nicozol® helps you restore your geriatric patients' interest in themselves

NICOZOL therapy can help you brighten the outlook of your aging patients who tend towards (1) untidiness, (2) irritability, (3) incompatibility, (4) lack of interest, and (5) loss of memory or alertness.

The NICOZOL formula helps improve mental acuity, increase the supply and use of oxygen in the brain, improve peripheral circulation—without excitation, depression, or other untoward effects.

NICOZOL can help you keep your aging patients actively alert and at ease with themselves, their families, and others.

Supplied: NICOZOL tablets (and capsules) in bottles of 100 and 1000. NICOZOL elixir in pints and gallons.

Precautions: May produce overstimulation in high doses. Discontinue if muscular twitchings or clonic convulsions occur. The flush produced in sensitive individuals is transient and harmless.

Average Dose: 1 to 2 tablets (or capsules) 3 times a day. 1 teaspoonful elixir 3 times a day.

Formula: Each tablet or capsule contains: Pentylenetetrazol........... 100 mg. Nicotinic Acid.... (as the sodium salt) Alcohol....

Division of A. J. Parker Co.

HART
LABORATORIES
Bryn Mawr, Pa., Winston-Salem, N.C.

NICOZO]

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin, brand of dipyridamole

See next 3 pages

Study 1.

Griep, A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:

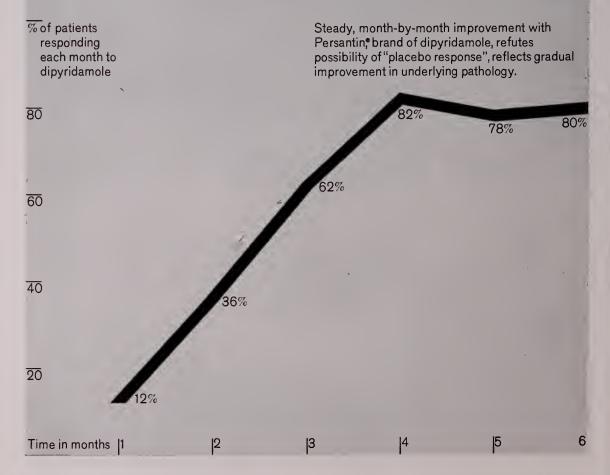
A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin, brand of dipyridamole, 25 mg. t.i.d. or q.i.d., was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis.

Persantin® brand of dipyridamole

"..long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients...

"relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"



Study 2.

Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin, brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

Geigy

After 3 months, 32 of 40 patients showed:

"...reduction or abolition of acute anginal attacks...

"complete or almost complete disappearance of ECG abnormalities...

"marked increase"in walking distance without anginal symptoms

% of patients

80 In 80% of patients: 4-fold or greater In 75% of increase in maximal patients: walking distance anginal attacks before anginal symptoms In 65% of patients: eliminated ECG normal 60 or improved 40 20

Persantin® brand of dipyridamole

How long-term therapy provides clinical benefits reported on previous pages

1. By increasing energy yield

of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).¹⁻⁵

2. By improving collateral coronary circulation.

Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.⁶⁻⁹

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:

Tablets of 25 mg., bottles of 100 and 1000. Under license from Boehringer Ingelheim G.m.b.H. Prescribing summary: Persantin, brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962.9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.



Geigy Pharmaceuticals Division of Geigy Chemical Corporation Ardsley, New York, Distributors

PE-229



ACHROCIDIN

TETRACYCLINE HCI-ANTIHISTAMINE-ANALGESIC COMPOUND

Each Tablet contains: Caffeine Salicylamide Chlorothen Citrate Salicylamide ACHROMYCIN® Tetracycline HCI . . 125 mg. Acetophenetidin (Phenacetin) 120 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets four times daily.





In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

- 1. A sprain or fracture is not a big clinical problem but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.
- 2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains-and more potent products too often make the patient feel 'dopey'.
- 3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness ("numbs the pain...not the patient").

- 4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.
- 5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma Compound



carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma Compound + Codeine

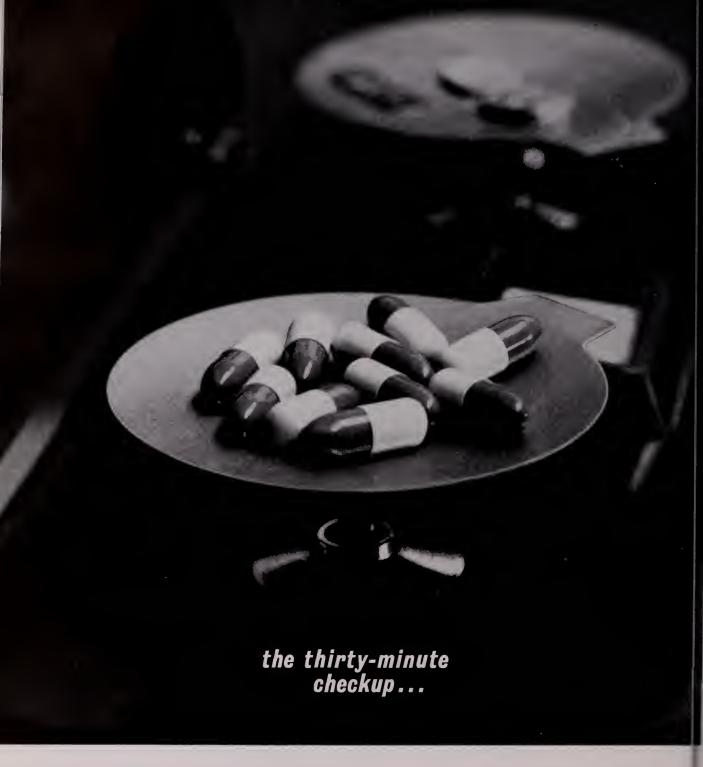
carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning-may be habit forming.)

Wallace Laboratories / Cranbury, N. J.



Your recommendation of **Coricidin** assures responsible treatment of common colds. For added decongestant action, recommend Coricidin "D" Decongestant Tablets.





Empty capsules are filled by the finest precision machinery available . . . but no machine is perfect. That's why all Lilly Pulvules® (filled capsules) are given the "thirty-minute checkup" to be certain that uniformity is maintained. At least once every thirty minutes ten filled capsules are taken from

each machine and carefully weighed on a prescription balance. In addition, the checks are double-checked at least four times each day . . . another of the many stringent controls which assure you that the Lilly products you prescribe provide quality that merits the full measure of your confidence.

Lilly

The JOURNAL

of the Florida Medical Association

Fluids and Electrolytes in Burns

J. FREDERICK EAGLE, M.D. NEW YORK, N. Y.

The effects of a large thermal burn may be briefly summarized as follows: there is a large rapid loss of fluid, electrolytes, and protein from the intravascular compartment. Part of this loss is through the site of the burn and is permanently lost from the body, but frequently there is an even greater loss from the damaged capillaries into the interstitial spaces about the traumatized area. In an attempt to maintain the circulation, intracellular water leaves the cells, but this compensatory mechanism is usually inadequate, the patient goes into shock, and tissue anoxia finally kills him.

Effective therapy is designed to prevent this sequence of events and has as its primary objective the maintenance of an adequate circulation which will prevent tissue anoxia and maintain tissue function, particularly renal function. It is most desirable to have the major organ which is involved with regulation of water, electrolyte, and acid-base balance working with the physician and correcting his mistakes, rather than depending on the physician to know all the answers.

Actually, it is relatively easy to maintain circulation. It can be done with blood, plasma, saline, plasma expanders such as dextran, or various combinations of these fluids. Difficulties arise from the fact that maintenance of circulation with one or more of these fluids usually creates new problems-iatrogenic problems-and the history of parenteral fluid regimens as proposed by Harkins, Cope, Evans, the Brooke Army Hospital Group, and others, shows that when these formulas fail, it usually is not because they do not

maintain an adequate circulating volume, but because the patients cannot handle the new situations created by therapy.

The Problem

The major problem created by therapy involves the sequestration of water, protein, and electrolytes as edema. This edema fluid accumulates at the expense of circulating fluid, and secondarily at the expense of intracellular water and its solutes. Although it is effectively lost from and not available for the circulation, it is not lost from the body. The amount can be very large. Water retention can exceed 10 to 15 per cent of the body weight, and the sodium retention can exceed the amount which normally exists in the entire body.

The edematous state by itself may not be lethal, but 48 hours after the burn, when capillary function returns toward normal, this edema returns into the circulation. The rate of return not infrequently exceeds the ability of the kidneys to excrete this fluid, resulting in an overloaded circulation, cardiac failure, pulmonary edema, and death.

This problem can be more precisely defined by asking how much of this edema is obligatory and how much is iatrogenic, in that it is caused by excessive administration of water, protein, and/or electrolytes. Or, to express it differently, how much water, protein, and electrolytes must we give in order to maintain an adequate circulation and at the same time minimize the accumulation of edema fluid?

There are several objective criteria that may be used to determine adequacy of circulation, such as blood pressure, pulse, hematocrit, and blood volume determinations, but the literature and our

Director of Pediatrics, St. Luke's Hospital, New York, N.Y.; Associate Clinical Professor of Pediatrics, Columbia University, College of Physicians and Surgeons, New York, N. Y. Read before the Florida Medical Association, Eighty-Ninth Annual Meeting, Hollywood, May 17, 1963.

personal experience suggest that the easiest and most sensitive guide is the rate of urine formation. We can assume that if urine formation is adequate, the circulation must be adequate. It does not follow, however, that the circulation is inadequate if urine output is inadequate.

I must emphasize this latter point because usually the emphasis is directed towards correcting the shock with the assumption that renal function and urine production will automatically resume when an adequate circulation has been restored. It is certainly true that restoration of an adequate circulation is a sine qua non, but, in order to have good urine flow it is equally necessary to have what the renal physiologists call "free water," that is, water which can be freed of the osmotically active ingredients. Without adequate electrolyte-free water there will be minimal urine output. In a patient with simple dehydration, that is, a patient with a high plasma osmotic pressure, neither blood, plasma, dextran, nor isotonic saline will increase urine output because they will not lower the osmotic pressure of the plasma. Under such circumstances only dextrose and water or some other hyposmotic solution will increase urine output.

This point is important, because although all formulas stipulate that a certain amount of electrolyte-free water must be given for insensible and renal losses, the fact of the matter is that in a 24 hour period, isotonic fluids are actually being administered over 60 per cent of the time.

This was brought home to us very strikingly following a school fire in Buffalo in 1954, when over 20 children were admitted within half an hour with major burns ranging in extent from 25 to 100 per cent of the body surface area. At the time we were using the Evans regimen and, generally speaking, a magnificent job was done, but critical re-examination of our efforts when we finally had time to evaluate them revealed that we had made a number of errors. They were partly due to the fact that less experienced personnel had to be utilized extensively because of the number of patients being simultaneously treated, and because decisions had to be made hourly around the clock and therefore of necessity by different physicians. They were due partly to the difficulty of adapting the Evans formula to children. Finally, for even the most experienced, it is very difficult to decide at any given moment whether a patient needs more saline, more plasma, more glucose and water, or more blood.

In retrospect, it dawned on us that these latter decisions are impossible to make on any rational basis. No severely burned patient ever needs just saline, or just dextrose and water, or just plasma. Such a patient actually requires all these ingredients—water, protein, and electrolytes—and ideally he should receive them all at exactly the same rate at which they are being lost from the circulation.

A Single Solution for Parenteral Therapy

Accordingly, we devised a single solution which contains protein and electrolytes in concentrations which were estimated to approximate the loss of these substances from the circulating plasma. This solution contains 2 per cent protein and 0.67 per cent saline. It was arrived at by a consideration of the formulas of Evans, Cope, and the Brooke Hospital Group, plus a consideration of the ease of making the solution with readily available material. All that need be done is to mix one unit of plasma with one unit of 5 per cent dextrose and water and one unit of 5 per cent dextrose in saline.* The effective osmotic pressure of this solution, that is, the osmotic pressure without considering the glucose which will be metabolized in the body, is less than that of plasma and will therefore continually stimulate urinary flow.

This single solution was derived chiefly from the extensive data of Cope and Moore, who measured the amount and composition of fluid lost from the burn site and the amount of edema which accumulated in patients with different types of burns. Their measurements were on adults, but, since I am a pediatrician, I have recalculated these data so that they will be applicable to children and persons of varying size. For this purpose I have utilized surface area which correlates well with most metabolic functions and, I might add, is just as useful in adults.

According to my recalculations of Cope's data, the losses through the skin are 30 ml. per square meter of body surface area per per cent body burn. This fluid contains one half the protein concentration of plasma and the same electrolyte concentration.

*A closed system is used for preparing this solution. The tops of three empty 1,000 ml. vacuum hottles are sterilized with iodine and alcohol, as is one 1,000 ml. bottle of plasma, one 1,000 ml. hottle of 5 per cent dextrose and water, and one bottle of 5 per cent dextrose and saline. One end of a blood donor set is inserted in the bottle of plasma and the other end consecutively into the vacuum hottles until 333 ml. has been transferred to each bottle. This procedure is repeated with the 5 per cent dextrose and water and the 5 per cent dextrose and saline. Should the vacuum be lost in any bottle before these maneuvers can be completed, it will be necessary to use a vacuum pump. For this reason it is advisable to mix this hurn solution in a blood bank where such equipment is usually available.

436 Volume 50 Number 6

Table 1.—Water, Protein, and Electrolyte Losses in Burned Patients in the First 48 Hours

TYPE	AMOUNT IN 48 HOURS	COMPOSITION
Loss of serum through burn Loss of plasma as edema Insensible water loss Urine water loss	30 cc. per square meter per % body burn 10% body weight in Kg. 2,000 cc. per square meter 2,000 cc. per square meter	1% sodium, 3.5% protein 1% sodium, 3.5% protein Plain water 0.6% sodium

WATER, PROTEIN, AND ELECTROLYTE LOSSES CALCULATED FOR A 30 KG., 1 SQUARE METER PATIENT WITH A 50% BODY BURN

	Water (cc.)	Sodiu	ım (Gm.)	Prote	in (Gm.)
Loss of serum through burn	$30 \times 1 \times 50 = 1,500$	15	(1%)	52.5	(3.5%)
Loss of plasma as edema	$30,000 \times 0.1 = 3,000$	30	(1%)	105	(3.5%)
Insensible water loss	$2,000 \times 1 = 2,000$	0	0	0	
Urine water loss	2,000 x 1 =2,000	13	(0.6%)	0	
Totals to be replaced	8,500	58	(0.6%)	157.5	(1.85%)

This is essentially a two-third normal saline solution with 2% protein. Similar calculations on patients of varying sizes and with burns of varying extent demonstrate that the range of saline concentration varies between 0.54 and 0.71% and the range of protein concentration varies between 1 and 2%.

The maximum amount of edema is an amount equal to 50 per cent of the extracellular water space, which is 10 per cent of the body weight. This edema fluid was assumed to have the same composition as bleb fluid, that is, one half the protein concentration of plasma and the same electrolyte concentration.

Insensible water loss requires 1,000 ml. per square meter per day or 2,000 ml. per square meter in two days. An adequate urine volume is about 1,000 ml. per square meter per day, or 2,000 ml. per square meter in two days. This fluid is essentially electrolyte-free, although since the kidneys cannot excrete distilled water, it is necessary to allow for electrolyte loss in the urine.

For instance, let us take a 30 Kg. patient with a surface area of one square meter who has incurred a 50 per cent body burn (table 1). We find that in the first 48 hours we must administer 30 ml. per cent body burn per square meter, or $30 \times 50 \times 1 = 1,500 \text{ ml. of fluid, with } 16 \text{ Gm. of }$ sodium chloride and 52.5 Gm. of protein in order to replace what is lost through the burn. We must administer 10 per cent of the body weight, or $30 \times \frac{1}{10} = 3 \text{ Kg.}$, or 3,000 ml. of fluid containing 30 Gm. of sodium chloride and 105 Gm. of protein in order to account for the loss of fluid into the interstitial spaces as edema. We must administer 1,000 ml. of fluid per day to account for insensible loss and 1,000 ml. of fluid with which to make urine, or 4,000 ml. in two days of a solution which is one third normal and, therefore, contains 13 Gm. of sodium chloride. Adding all this, we come up with 8,500 ml. of fluid containing 58 Gm. of sodium chloride (essentially a twothirds normal salt solution) and 157.5 Gm. of protein (essentially a 2 per cent protein solution).

Similar calculations on patients weighing from 2 to 80 Kg. with surface areas from 0.2 to 2 square meters, and with body burns from 15 to 50 per cent reveal that the salt content would vary from 0.54 per cent in the very small with 15 per cent burn, to 0.71 per cent in the very large with 50 per cent body burn or greater. The protein concentration varies from 1 to 2 per cent. It seems reasonable, therefore, to assume that proper amounts of an 0.67 per cent saline solution with 2 per cent protein will satisfy the requirements of a burned person of any size and at the same time not exceed the homeostatic mechanisms controlling the distribution and excretion of water, salt, and protein.

A comparison of the composition of this fluid with the amount of water, protein, and electrolytes which would be prescribed in 48 hours for a 70 Kg. person with 1.73 square meters body surface and a 25 per cent burn, according to the regimens of Cope and Moore, Evans, and the Brooke Hospital Group, is as follows:

Table 2.— Composition of Formulas

Source of	Fluid	Electrolyte	Protein
Formula	Ml.	Gm. NaCl	Gm.
Cope and Moore	8,624	47.6	196
Evans	8,250	44.2	182
Brooke Group	8,251	44.2	91

It is apparent that the three formulas are very similar, except for the protein content in the Brooke formula which is 50 per cent of the other figures. This lower protein content was arrived at partly because electrolyte solutions are much cheaper and can be secured in larger quantities in time of disaster.

If the amounts of the various solutions used in these formulas were combined into a single solution, Cope's formula would contain 0.55 per cent saline and 2.2 per cent protein; Evan's formula would contain 0.54 per cent saline and 2.2 per cent protein; and the Brooke formula 0.54 per cent saline and 1.1 per cent protein.

Rate of Administration

These three formulas all require that one third of the mixture of the calculated 48 hour requirement be given in the first eight hours after the burn; one third during the second 16 hours, and one third during the second day. This is obviously only an order of magnitude since it is highly unlikely that fluid requirements in the ninth hour would be only one half the amount required during the eighth hour. The fluid requirements are certainly going to be high in the early hours after the burn, but then they will decrease gradually until the end of the second day when fluid starts to return to the circulation, at which point it may be necessary to restrict fluid intake entirely.

We make these calculations not for the purpose of estimating needs over a 48 hour period but only for the purpose of estimating a rate at which to start the infusion. In adults, these calculations are probably not necessary, and we recommend starting the infusion at 20 ml. per hour for each per cent body burn, or, if therapy has been delayed, at a rate so that 160 ml. for each per cent body burn is administered by eight hours after the burn. At this rate urine output should come into the normal range within two or

Table 3.—Correlation of Fluid Intake With Extent of Burn

Extent of Burn Per Cent	Initial Rate of Infusion, Ml./Hr.	Desired Urine Output Ml./Hr.	Input/ Output
50	1,000	60	16.6
45	900	60	15.0
40	800	60	13.3
35	700 -	60	11.5
30	600	60	10.0
25	500	60	8.3
20	400	60	6.7

three hours of the start of therapy. For adults, a normal urine output would be 1 ml. of urine per minute, for a child, 40 ml. per square meter per hour.

In an adult, as soon as urinary output in any hour exceeds 60 ml. per hour, the rate of the infusion is slowed by 60 ml. per hour. In a child where a normal urine output might be 30 ml. per hour, the infusion is reduced 30 ml. per hour whenever urinary output exceeds 30 ml. per hour.

The ratio of necessary intake for desired output for burns of varying degrees is shown in tables 3 and 4.

For the most severe burn in an adult, the ratio of intake for desired output is 16.6 to 1 at the start of the infusion. (Incidentally, all burns greater than 50 per cent are treated as though they were 50 per cent.) This ratio will gradually fall until around the end of the second day, when it may fall below a normal 2 to 1 ratio as the edema fluid is mobilized.

Results

This type of parenteral fluid therapy has been used exclusively for the management of all burned

Table 4. — Starting Rate of Infusion (Ml. Hr.) For Burns of Varying Extent in Patients of Different Sizes

Surface Area	Weight	Optimal Urine Output —-					Ex	tent o	f Burn	
Sq. meters	Kg.	Ml., Hr.	20%	25%	30%	35%	40%	45%	50%	
0.2	3	8	51	52	53	54	56	57	58	
0.4	8	16	110	112	115	117	120	122	125	
0.6	15	24	178	181	185	188	192	196	200	
0.8	23	32	250	255	260	265	270	275	280	
1.0	30	40	317	323	329	335	341	348	354	
1.2	40	48	396	404	411	419	427	435	442	
1.4	50	60	476	485	494	503	512	519	528	
Adults		60	400	500	600	700	800	900	1,000	

If the rates for adults were calculated in the same way as they are for children, the starting rate would be greater than 20 ml. per per cent body surface burn for burns less than 30%, and less than 20 ml. per per cent body surface burn for burns greater than 30%. In the latter instances the faster rates are desirable because intravenous therapy usually cannot be started until one or more hours after the burn, and it is advisable to make up this deficit rapidly. In any event, one should be prepared to increase the rate of infusion if urine output is not adequate, and decrease it when urine output exceeds optimal values.

patients admitted to the Meyer Memorial Hospital, Buffalo, N. Y., for the past eight years and at St. Luke's Hospital, New York City, for the past six years.

The staffs have been impressed by the ease of management and the virtual absence of fluid and electrolyte problems. The fact that water, salt, and protein are being continually replaced in approximately the same proportions and at the same rate at which they are being lost is particularly appealing.

Thirty-five patients with burns of 15 per cent of the body surface area or greater have been treated.

There was only one death in the first 48 hour period. This occurred in an 80 year old woman with a 35 per cent body burn in whom pulmonary edema developed, and she died during the second day. She obviously received too much fluid, however, and this should have been apparent during the first 24 hours when she excreted 2,300 ml. of urine instead of a more desirable output of 1,500 ml. This death probably represents a failure to utilize the regimen properly rather than a failure of the regimen itself.

This parenteral fluid program has not influenced the over-all mortality. Fourteen of these patients died between the fourth and thirty-fifth day. Extensively burned patients and elderly people with lesser burns still die from infection, pneumonia, inanition, and other pre-existing disease which might not have been lethal had the patient not been burned. Also, a fair number of deaths occur a week or more after a burn which cannot be adequately explained by clinical, laboratory, or pathologic observations.

Comment

While I am on safe ground when I limit myself to our actual experience, I would now like to speculate on how this regimen might be improved. These remarks are prompted by discussions with several persons who may or may not have tried this regimen and who have different opinions regarding therapy.

First, could the composition of this single fluid be improved? Theoretically, the answer is yes. A simple improvement would be to substitute Ringer's lactate solution for the unit of dextrose and saline. This would more nearly approximate the concentrations of sodium and chloride in the plasma and therefore would relieve the kidney from the task of excreting the extra chloride. It is conceivable that the addition of phosphate, calcium, and magnesium might improve things, but I rather doubt this, believing that enough of these ions are probably present in the plasma.

Potassium replacement has been controversial. in spite of good evidence that there is considerable potassium loss. Originally, I suggested adding 20 mEq/L of potassium as soon as one could be sure of good renal output. This proposal met with vigorous objections from the surgeons who point out that the serum potassium tends to be high during the acute phase as it leaks out of dead and dying cells. This is certainly true, but major renal dysfunction also is practically always present, and it is doubtful that the serum potassium could ever rise to lethal levels if urinary output is adequate. Metcoff has recently shown that the loss of potassium after correction for nitrogen loss indicates a deficit of about 3 per cent of the potassium contained in the residual, intact body tissues. What has not been shown, however, is whether this loss can be prevented by the administration of potassium. Studies in diabetic acidosis suggest that it can be prevented partially at least. Personally, I would favor adding 20 to 30 mEq per liter of potassium to this solution, but I do not know that it would make any difference; I do know that most surgeons are afraid even to try it.

Finally, it has been suggested by some, particularly Fox and Metcoff, that our method calls for too much fluid. Fox has been saying for a long time that all regimens call for too much fluid, and his data show that scald burns and charred burns are entirely different, the former requiring much more fluid than the latter. Assuming he is correct, and I have no reason to doubt him, it is my contention that this careful monitoring of intake according to the urinary output will automatically adjust not only for this contingency but also for other possible errors of clinical judgment, particularly the size of the burn and its severity, estimates of which I think are usually quite inaccurate.

Metcoff's objection is more serious. He contends on the basis of extensive metabolic studies in four patients that renal function is inevitably compromised, and that any regimen based on urinary output is bound to administer too much fluid. His serum and urine osmotic determinations, however, were high, and he gives no detailed information about the type of fluid which was administered. I suspect that his patients were actually dehydrated. Furthermore, he told me that

the patients' protocol which I used as an example almost exactly corresponded to his estimates of the patients' needs.

I can only say that this method works. If anybody wants to limit urinary output to 20 ml. per hour, I would not seriously object, but lower than 10 ml. an hour makes me worry that the circulation is not adequate or that we are dealing with lower nephron nephrosis. This latter complication, I am told, has practically disappeared where prolonged shock can be avoided.

Summary

In summary, I have presented our experience with a single fluid for the parenteral therapy of major burns in the first 48 hours. It contains 2 per cent protein and 0.67 per cent saline. Since it is hypotonic, it will stimulate urine output, and our experience has supported our assumption that if urine output is adequate, all other requirements for protein and electrolytes will be satisfied.

Electrocardiographogenic Suicide and Lesser Crimes

HENRY J. L. MARRIOTT, M.D. TAMPA

The electrocardiograph is regarded as a relatively harmless weapon, but, like the automobile, it depends on who is handling it. The combination of electrocardiograph and incompetent interpreter can be seriously damaging, and even lethal. Three true stories illustrate five of the serious crimes this sinister combination can perpetrate (table 1).

Table 1.- Electrocardiographogenic Crimes

- 1. Cardiac neurosis
- 2. Insurance denial
- 3. Nuptials postponed
 - Robbery
- 5. Suicide

A 32 year old dentist experienced pain in the chest for which he consulted a well known cardiologist. Without obtaining an adequate history, the cardiologist obeyed the deplorable twentieth century reflex, chest pain → electrocardiogram, and took a tracing. This showed an unusual ST-T pattern in right precordial leads suggestive of acute anteroseptal injury (fig. 1A). The dentist, protesting, was deposited in a hospital bed and shrouded in an oxygen tent. Next day the T waves in V2 were frankly inverted (fig. 1B) and evolution of the diagnosed infarction was assumed. No constitutional symptoms developed, however, and vital signs, leukocyte count, and sedimentation rate remained normal. At the end of three days, oxygen was discontinued. No further evolution in the electrocardiogram occurred, and at the end of three weeks the dentist was discharged with a diagnostic compromise, pericarditis, of which there had been no substantial evidence.

Eighteen months later he visited another cardiologist for a check-up. An electrocardiogram was taken (fig. 2) and the dentist was rightly assured that it was normal. Note that the ST-T pattern previously seen in V_2 in figure 1A persists in modified form.

A year later the dentist again experienced chest pain which he said was identical with his initial attack. He was seen by a third cardiologist on this occasion who took a history and elicited among other points that, sitting or lying, the pain disappeared if he kept absolutely still and that the pain was worse when he stood on his left rather than on his right leg-features that hardly suggest cardiac pain. Furthermore, the electrocardiographic pattern was immediately recognized as one that Edeiken1 drew attention to as a normal variant in 1954. Further exploratory leads taken at that time from interspaces above the conventional (fig. 3) showed all the previously seen ST-T contours and established them as stable patterns.

COMMENT.—As a result of faulty history taking and uninformed electrocardiographic interpretation, this busy dentist lost weeks of work and thus suffered the equivalent of robbery,

Director, Medical Education, and Director, The Cardiology Center, The Tampa General Hospital. Read before the Florida Medical Association, Eighty-Ninth Annual Meeting, Hollywood, May 16, 1963.

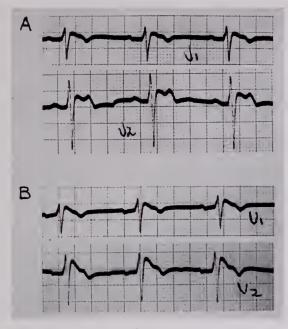


Figure 1

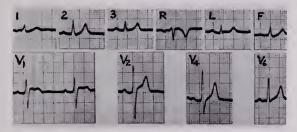


Figure 2

acquired a cardiac neurosis and was denied needed life insurance. He has subsequently regained the grace of unrated insurability.

A 20 year old college football player, two weeks before his intended marriage, experienced a sharp pain in the chest. In fairness to his imminent bride, he made the mistake of going to his doctor for a check-up. The physician administered a reassuring slap on the back, but in turn made his mistake by taking an electrocardiogram -"just to be sure." To his consternation there was incriminating S-T elevation in V₄₋₆ with T wave inversion in V₄ (fig. 4). He referred him to a cardiologist who, enthralled by the electrocardiogram, committed him to a hospital for an "acute myocardial process." With the patient incarcerated in the hospital, concerned about his heart, and faced with postponement of his marriage and all that this entailed, the heart rate rose from an athletic 60 to a nervous 90 and the T waves took a nose dive (fig. 5). This T wave behavior, combined with ignorance of the effects of anxiety on the electrocardiogram, suggested evolution of an infarction pattern and ensured the football player's further detention. Vital signs, leukocyte count, sedimentation rate, transaminase levels and even a ballistocardiogram were all disarmingly normal. Serial electrocardiograms showed equivocal fluctuations in the ST-T pattern and at the end of six weeks the football player was discharged with the advice to "take it easy" and postpone his wedding for several months, but the knot was finally tied and the marriage gingerly consummated. After a year of

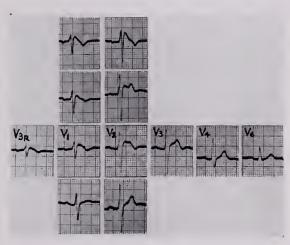


Figure 3

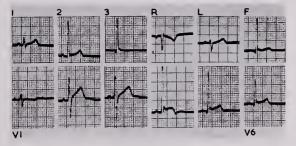


Figure 4

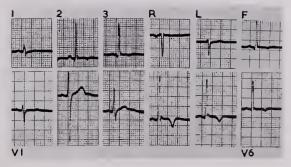


Figure 5

maddening marital moderation, he decided to seek advice at another medical center. Here they took an electrocardiogram, found a similar pattern and put him to sleep with a large dose of sodium amytal. The T waves "righted" themselves and the pattern was recognized for what it was-a normal variant similar to many already published.2 His heart was acquitted, and the football player returned to his young bride, we hope to love happily ever after.

COMMENT.—A healthy and robust young athlete had his life seriously dislocated and acquired a cardiac neurosis through inadequate attention to the clinical picture and overreliance on the electrocardiogram.

The pathetic story of a medically manslaughtered bus driver is told by Evans.3 With a pain in his chest, he reported to his physician, who promptly put him to bed with the diagnosis of myocardial infarction. A consultant was called in who took an electrocardiogram and confirmed the diagnosis of "angina." The driver was kept in bed for six weeks and then allowed a gradual return to activity; but when he tried to resume his job, the company preferred not to re-employ him with his cardiac history. After trying vainly for weeks to secure other employment to support his invalid wife and four children, he gave in to depression and threw himself into the river. At necropsy, the myocardium was hale and hearty and the coronaries clean and patent.

COMMENT.—Faulty interpretation and undue reliance on the electrocardiogram indirectly led to this man's death-a clear case of electrocardiographogenic suicide.

Conclusion

The moral to be learned from mishaps such as these is plain. The electrocardiogram is not to blame; it is the man in the driver's seat. There is a deplorably swift transfer in the diagnostician's mind from the complaint of chest pain to the taking of an electrocardiogram with resulting neglect of the most important component of all diagnostic work-ups even today-a careful history. When such clinical neglect is combined with inadequate knowledge of the limitations of electrocardiography, the results may be catastrophic for the individual victim.

Safeguards against such catastrophes are, first, a proper reliance on a good old-fashioned history; and second, an adequate knowledge of the many electrocardiographic mimics of coronary disease.4 The juvenile pattern, especially common in Negroes, the effects of hyperventilation, the syndrome of the "suspended heart," the effects of drinking iced water, and countless other imitators should be familiar to anyone who undertakes to interpret an electrocardiogram. One important precaution that seems to be consistently overlooked is that any person with equivocal ST-T changes should have a fasting tracing.

References

- Edeiken, J.: Elevation of the RS-T Segment, Apparent or Real, in the Right Precordial Leads as a Probable Normal Variant, Am. Heart J. 48:331-339 (Sept.) 1954. Goldman, M. J.: Normal Variants in the Electrocardiogram Leading to Cardiac Invalidism, Am. Heart J. 59:71-77 (Jan.)

- Evans, W.: Faults in the Diagnosis and Management of Cardiac Pain, Brit. M. J. 1:249-254 (Jan.) 1959.
 Marriott, H. J. L.: Coronary Mimicry: Normal Variants, and Physiologic, Pharmacologic and Pathologic Influences That Simulate Coronary Patterns in the Electrocardiogram, Ann. Int. Med. 52:413-427 (Feb.) 1960.

November Issues of The Journal Wanted

A shortage in the supply of the November, 1963, issue is preventing The Journal from filling urgent requests from members of the Association.

If you will part with your copy of the November issue for a good cause, please send it to The Journal, P.O. Box 2411, 735 Riverside Ave., Jacksonville 3, postage collect.

Carcinoma of the Inner Canthus and Lacrimal Apparatus

RICHARD T. FARRIOR, M.D. TAMPA

The general physician should be familiar with the entity of primary carcinoma of the lacrimal sac, but perhaps more important, he should be aware of the dangers and complications which arise from the more common extension to this area of adjacent skin neoplasms. Many of these neoplasms are slow-growing and should not be allowed to progress to the degree that excision of the functional area of the inner canthus becomes necessary. Early detection and adequate primary treatment not only increase the cure rate, but allow preservation of function or simplify reconstruction.

Similarly, the otolaryngologist, ophthalmologist, or head and neck surgeon should not procrastinate and should learn to distinguish between the deeper obstructing neoplasms, for instance, and chronic dacryocystorhinitis. This paper is intended as a brief review for the general physician and the specialist of the nature of these lesions and of the reconstructive techniques employed following excision.

Primary carcinoma of the lacrimal excretory apparatus is rare. Carcinoma extending from adjacent structures, however, to involve the inner canthus, lacrimal sac, or nasolacrimal duct is not uncommon.

Following the theme of progressing more and more towards the preservation and restoration of function in our excisional and reconstructive surgery, this subject was selected. In order to emphasize attention to detail in this perhaps lesser area where the main function is simply the funneling off of tears, yet where the preservation of this function can become a major problem or at least a major nuisance to the patient when disturbed, a review would seem useful. Reconstruction may require bridging a portion of the existing lacrimal passages or rerouting and funneling directly into the lateral wall of the nose.

We are dealing with epithelial tumors in 50 per cent to 60 per cent of the cases of primary neoplasm of the lacrimal sac (tables 1 and 2). The sarcomata, however, are next in oc-

Read before the Florida Society of Ophthalmology and Otolaryngology, Hollywood, May 18, 1963.

currence, and the eyelid contains, of course, ectodermal and mesodermal structures and essentially all the skin appendages from which tumors may arise. The epithelium extending from the puncta to the inferior meatus will perhaps continue to bridge the specialties of otolaryngology and ophthalmology, which are at least historically related. Cooperation and on occasion a combined surgical approach cannot be overemphasized.

The collected cases of Duke-Elder (table 2) refer as far back as 1722 to Janin's Memoir, and only 62 of these are malignant—the carcinoma, sarcoma, and melanoma. I would emphasize, however, the premalignant nature of the papilloma. Jones' series is the largest collected by a single author since Duke-Elder's survey. All in all, not over 100 cases have been reported.

Primary tumors, then, are rare, though we all frequently see tumors from the adjacent skin,

Table 1.—Ectodermal Origins of Carcinoma of Lacrimal Apparatus (Naso-optic Furrow)

г	т		1 (.
1	1.2	crima	i Sac

Columnar ciliated epithelium Stratified columnar epithelium

II. Canaliculi

Stratified squamous epithelium

III. Conjunctiva

Stratified columnar epithelium

Stratified squamous epithelium (palpebral margins)

IV. Eyelid

Stratified squamous epithelium

Table 2.—Varieties of Neoplasms of Lacrimal Apparatus

Duke-Elder	
Pseudotumors: granuloma	26
Epithelial tumors	
papilloma	11
adenoma	2
pleomorphic adenoma	2
carcinoma	39
Mesenchymal tumors	
fibroma	3
sarcoma	20
Reticuloses	11
Malignant melanoma	3
	117
Jones	2
Squamous cell carcinoma	3
Lymphoma	2
Kaposi sarcoma	1
	_
	6





Fig. 1.—Radical Rhinotomy Across Nasolacrimal Duct. This case is included to show sectioning of the nasolacrimal duct where there has been removal of the lateral wall of the nose. I would encourage suturing the lining of the duct to the nasal mucous membrane and stinting with a relatively large polyethylene tube. The tube can be seen extending into the nose in the midportion of the defect. No epiphora occurred. Figure 1b illustrates the postoperative appearance.



Fig. 2.—Bipedicle Eyelid Graft. The entire lower lid, including the canaliculus, was excised for squamous carcinoma. A bipedicle upper lid graft based wide of each canthus was swung from the upper lid. A large canaliculus was constructed with a graft from the opposite lid folded about a polyethylene tube with the raw surface out.



eyelid, or nasal mucous membrane which require resection of a portion of the lacrimal apparatus or inner canthus. We should, therefore, be familiar with reconstructive procedures in this area.

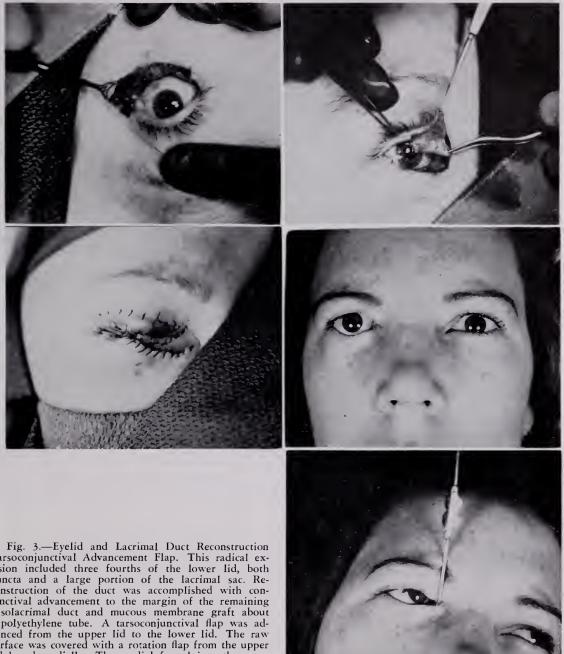
Table 3.—Symptoms of Carcinoma of Lacrimal Sac

State I. Epiphora Stage II. Simulated dacryocystitis

Stage III. Nonreducible swelling Stage IV. Extension of tumor

The stages in table 3 depict the progression of the disease, and one should maintain a high index of suspicion in the case of persistent epiphora or dacryocystitis.

In the presentation Kodachrome slides were shown to illustrate the normal and the pathologic histology of the lacrimal area. Examples were shown of chronic dacryocystitis, primary carcinoma, including pseudoglandular cyst formation, squamous cell carcinoma arising in a papilloma of



Tarsoconjunctival Advancement Flap. This radical excision included three fourths of the lower lid, both puncta and a large portion of the lacrimal sac. Reconstruction of the duct was accomplished with conjunctival advancement to the margin of the remaining nasolacrimal duct and mucous membrane graft about a polyethylene tube. A tarsoconjunctival flap was advanced from the upper lid to the lower lid. The raw surface was covered with a rotation flap from the upper lid based medially. The medial funnel into the nasolacrimal duct readily admits a number 8 lacrimal probe.

the lacrimal sac, transitional cell carcinoma of the lacrimal sac, basal cell carcinoma with central necrosis and pseudocystic formation, adenoid cystic carcinoma pattern in a basal cell carcinoma, and an anaplastic squamous cell carcinoma of the evelid.

Figure 1 illustrates a case of undifferentiated carcinoma of the transitional cell type, which involved the lateral wall of the nose and the nasolacrimal duct. A radical lateral rhinotomy was performed, and use of the polyethylene tube for maintaining the patency of the duct is demonstrated. There was no postoperative epiphora.

Although basal cell carcinoma is the most common lesion of the lower eyelid, figure 2 is an example of squamous cell carcinoma involving the inferior puncta, canaliculus, and entire lower lid. The canaliculus was reconstructed with a polyethylene tube wrapped with a full thickness skin graft from the adjacent eyelid, raw surface out.







Fig. 4.—Lined Forehead Flap to Inner Canthus and Lateral Wall of Nose. The entire lacrimal area and the lateral wall of the nose were excised en bloc. A split thickness skin graft was utilized to line the forehead rotation flap and cover the donor area. A direct funneling of tears through the rhinostomy was effected.

A bipedicle graft from the upper lid was utilized to reconstruct the entire lower lid.

Figure 3 illustrates the case of a 26 year old woman who was treated for several years by an ophthalmologist for chronic dacryocystorhinitis and had had previous x-ray therapy. The patient presented with a basal cell carcinoma extending from the lacrimal sac to the middle of the lower lid. Excision included both canaliculi, the lacrimal sac well into the duct, and better than half of the lower lid. In reconstruction the fundamental principle of splitting the lid at the skin-conjunctival junction (along the gray line) was utilized, producing a tarsoconjunctival flap for transfer to the lower lid. The skin-muscle layer was replaced to outline the palpebral fissure. A rotation flap from the upper lid was utilized to cover the raw surface. A conjunctival advancement flap was fashioned from the fornix and semilunar fold area, and a direct funnel to the remaining duct was established. This was also splinted with a polyethylene tube, which was left in place until it came out six weeks later. Postoperatively, the patient had minimal epiphora and certainly far less than she

had for years from the simulated dacryocystitis and complete obstruction. Three years later the duct dilates readily to a number 8 lacrimal probe and there is essentially no epiphora.

In figure 4 there was a large tumor involving the inner canthus by spread from the adjacent skin. The entire lacrimal area and the lateral wall of the nose were excised en bloc. A rotation flap from the forehead was necessary. A split thickness skin graft was utilized to cover the donor area, as backing of the flap to line the excised lateral wall of the nose and the direct rhinostomy leading straight into the nose.

The final example shown in figure 5 required excision of a large section of the inner canthus, the lacrimal sac, both upper and lower puncta, and a separate section of the laterally situated lesion of the lower lid. There had been previous irradiation and surgery with the resulting scarring. What was essentially an Indian flap was utilized. The base of the flap was returned to the forehead to reduce the size of the split thickness graft over the donor site and provide better coverage over the supraorbital ridge. In the area of



Fig. 5.—Forehead Flap. This is another case for further details of reconstruction about the inner canthus with the forehead flap and the use of the polyethylene tube for stinting the duct lined with conjunctiva, mucous membrane and a portion of full thickness skin graft from the upper lid. A tarsoconjunctival flap was utilized further to reconstruct the lower lid. The base of the flap has been returned to the forehead. Note the polyethylene tube which will remain in until there is complete healing. At a later date the medial fornix and funnel were deepened with a free vein graft.

the inner canthus the flap was lined with a split thickness skin graft. This graft along with an advancement flap of conjunctival mucous membrane was carried to the margin of the remaining lacrimal duct. A tarsoconjunctival flap was transferred from the upper lid for added support to the lower lid. In a later stage the medial fornix and funnel to the reconstructed lacrimal duct were deepened with a vein graft. The polyethylene tube is allowed to extend over the upper lid until complete healing occurs. Defatting of the flap will be done as a later stage.

Conclusion

The general physician, as well as the specialist, should be aware of lesions in this anatomic location and strive for early detection and adequate initial therapy. Reconstructive surgery for this location offers particular problems and requires individualized techniques.

It would seem worth while for the head and neck surgeon to be familiar with reconstruction in the area of the inner canthus and apply our combined thinking towards improved techniques.

Maintaining a lacrimal excretory passage has received the same inspired variety of attention as the nasofrontal duct, with the full gamut of gold and silver tubes, mucous membrane grafts, skin grafts, flaps, and other measures. Polyethylene tubing has proved useful in our hands, but I do not think that it is by any means the final answer. Where lining is required, I am leaning more towards buccal mucous membrane rather than skin for a free graft. I have gone through the thought process of stealing from the otologist and using a vein graft as a tube, but have not used this except as described in the last case presented here. Perhaps some of the readers will have occasion to try this.

I trust that this review will assist the general physician, giving him some information to carry to his own patients. At the same time I hope this has not been too fundamental a coverage for the head and neck or reconstructive surgeon and that perhaps some of these techniques will assist him in future particular surgical situations.

References

Duke-Elder, Stewart: Tumors of the Lacrimal Passages, in Text-Book of Ophthalmology, Vol. V, The Ocular Adnexa, St. Louis, The C. V. Mosby Company, 1952, pp. 5346-5358.

Farrior, R. T.: Carcinoma of Inner Canthus and Lacrimal Apparatus, A.M.A. Arch. Otolaryng. 77:268-270 (March) 1963.

Fox, Sidney A.: Ophthalmic Plastic Surgery, New York, Grune & Stratton, Inc., 1952.

Hogan, M. J., and Zimmerman, L. E.: Lids and Lacrimal Drainage Apparatus, Chap. 1V in Ophthalmic Pathology, Philadelphia, W. B. Saunders Company, 1962, pp. 168-225.

Ilughes, Wendell L.: Reconstructive Surgery of the Eyelids, St. Louis, The C. V. Mosby Company, 1954.

Jones, I. S.: Tumors of the Lacrimal Sac, Am. J. Ophth. 42:561-566 (Oct.) 1956.

Tinglies, N. Color, St. Louis, The C. V. Mosby Company, 1954.

Jones, I. S.: Tumors of the Lacrimal Sac, Am. J. Ophth.
42:561-566 (Oct.) 1956,
Penman, G. G., and Wolff, E.: Primary Tumours of Lacrimal Sac, Lancet 1:1325-1328 (June 11) 1938.

Bayshore Boulevard at Hyde Park Avenue.

Varicella in the Newborn

DAVID MULTACH, M.D. AND HARRY KAUFMAN, M.D. NORTH MIAMI BEACH

Varicella in the newborn occurs rarely, a review of the literature yielding only 22 cases in which the eruption began within 10 days after birth. Fourteen cases1,2 occurred between the first and sixth day, and all of the infants made uneventful recoveries. The other eight cases 1,3,6-8 occurred between the seventh and ninth day of life and in four of these complications developed and the infant died.

In Baron's case⁶ the rash developed on the eighth day of life and the patient died with cyanosis and convulsions on the twelfth day. In Oppenheimer's case? the rash developed on the seventh day of life and respiratory distress on the eleventh day. Lucchesi8 reported a case in an infant eight days of age who died on the twelfth day. Ehrlich, Turner and Clarke³ reported the case of an infant in whom the rash developed at the age of seven days and was followed by pneumonia with death ensuing on the twelfth day of life. The common picture in the fatal cases is that of the primary disease followed in four to five days by a more severe involvement and death. The purpose of this article is to report an additional case of neonatal varicella in which, despite extensive involvement and complications, the infant lived.

Report of Case

In a white woman, gravida II, para I, varicella developed two days before delivery. The infant was a normal term female, weighing seven pounds six and one-half ounces. On the ninth day of life, a typical vesicular chiekenpox rash was noted on the face, trunk and extremities. On the thirteenth day of life, the rash became hemorrhagic. On the fourteenth day, grunting respirations and abdominal distention developed and the infant was admitted to Jackson Memorial Hospital.

Examination on admission revealed an acutely ill, tachypneic infant with abdominal distention. Generalized convulsions began soon after admission and continued during the first 24 hours of hospitalization. An x-ray of the chest and abdomen on admission showed a generalized pneumonitis, and dilated loops of bowel interpreted as paralytic ileus. Feedings were stopped; oxygen, procaine penicillin and intravenous fluids with convalescent varicella serum were given. The pneumonitis slowly improved over the next 10 days, but the abdominal distention remained.

Oral feedings were twice attempted, but the patient began vomiting several hours after each attempt. Paralytic ileus, mechanical obstruction, and perforation were considered. A barium enema revealed an obstruction at the terminal ileum, and on the tenth day of hospitalization the patient was operated on by Dr. Michael M. Gilbert.

At operation, gangrene of the terminal 10 inches of small bowel with a perforation of the ileum a few inches proximal to the cecum was present. This portion of the bowel was resected, and an end to end anastomosis was performed. The patient was fed three days after the operation, but a fistula draining through the operative incision developed on the fourth postoperative day.

A Gastrografin study revealed a fistula which appeared to originate in the terminal ileum. It was considered at this time that the patient's condition would not allow further surgery, and the prognosis appeared poor. It was

decided to stop all oral feedings and feed only intravenously, with Lipomul, Amigen, distilled water and saline in the hope that the fistula would heal through disuse. The fistula ceased draining 12 days after recessation of oral feedings, and oral feedings were again begun. Loose stools were noted seven days after beginning feedings. After three days once again on nothing by mouth with intravenous therapy, oral feedings were attempted, this time successfully, and the patient was discharged on the fortyeighth day of life, eating and gaining on Enfamil, cereal, applesauce, and bananas. She had been maintained on intravenous feedings alone for a total of 17 days. The birth weight of seven pounds six and one-half ounces dropped to four pounds seven ounces at the low point following the operation and fistula drainage, and was back to five pounds 10 ounces at discharge.

At home, intermittent loose stools were noted, and two weeks after discharge a coagulase-positive hemolytic staphylococcus was cultured from the stools. She was treated with Prostaphlin, 125 mg. three times a day for

two weeks.

Further cultures showed no staphylococci, and the stools remained formed. The patient is now seven months old and weighs 15 pounds. Growth and development have caught up to completely normal levels.

Comment

In view of the seriousness of neonatal varicella beginning at age seven to nine days, the prognosis should be guarded in cases of this age range. Several questions remain to be answered. Is there a time increase in dissemination of varicella at age seven to nine days? Does the gravity of varicella diminish when acquired beyond 10 days of age? Unfortunately, in older infants, cases have been of little interest and are not recorded in the literature. If there is a cluster of serious cases at this age, is this explainable with present knowledge? It is believed that cortisone therapy induces dissemination of varicella. Does the stress of labor produce cortisone sufficient to alter the course of certain cases of varicella?

Initially, intravenous convalescent varicella serum was given. In future cases of neonatal varicella contacts, 0.3cc./pound of gamma globulin should be given, and if varicella develops, possibly convalescent serum should be tried.^{9,10}

The final outcome was apparently changed by the administration of intravenous nutrients to this infant in a preterminal state for 17 consecutive days. The response to therapy was beyond expectations.

Summary

A case of neonatal varicella with dissemination is presented. This is the twenty-third reported case to date, and the first neonatal case with complications in which the infant survived.

References

- Freud, P.: Congenital Varicella, A.M.A. J. Dis. Child. 96:730-733 (Dec.) 1958.
 Jordan, E. O.: Neonatal Chickenpox, Henry Ford Hospital Medical Bulletin 5:296-302 (Mar.) 1957.
 Ehrlich, R. M.; Turner, J. A. P., and Clarke, M.: Neonatal Varicella, J. Pediat. 53:139-147 (Aug.) 1958.
 Readett, M. D., and McGibbon, C.: Neonatal Varicella, Lancet 1:644-645 (Mar. 25) 1961.
 O'Neil, R. R.: Congenital Varicella, A.M.A. J. Dis. Child. 104:391-392 (Oct.) 1962
 Baron, F.: Un cas se varicelle mortelle Chez le nouveau-né par contagion maternelle, Nourrisson 23:157-159 (May) 1935.
 Oppenheimer, E. H.: Congenital Chickenpox With Dis-Oppenheimer, E. H.; Congenital Chickenpox With Dis-seminated Visceral Lesions, Bull. Johns Hopkins Hosp.
- Oppenheimer, E. H.; Congenital Chickenpox With Disseminated Visceral Lesions, Bull. Johns Hopkins Hosp. 74:240-250 (Apr.) 1944.
 Lucchesi, P. F., and others: Varicella Neonatorum, Am. J. Dis. Child, 73:44-54 (Jan.) 1947.
 Funkhouser, W. L.: The Use of Serum Gamma Globulin Antibodies to Control Chickenpox in Convalescent Hospital for Children, J. Pediat. 32:257-259 (Mar.) 1948.
 Trimble, G. X.: Effect of Gamma Globulin in Chickenpox, Am Practificate 10:4364.27 (Mar.) 1959.
- Am. Practitioner 10:436-437 (Mar.) 1959.

16260 Northeast Thirteenth Avenue.

Volume 50 of The Journal ends with this issue, allowing only six instead of the usual 12 numbers. The House of Delegates in session at the Annual Meeting approved the resolution, originating within the Hillsborough County Medical Association, which directed that each volume begin with the calendar year in order to correspond with the other activities of the Florida Medical Association.—T.M.

President's Page

"Be of Good Cheer"

Christmas is coming! The old saying fills each one of us with excitement. It means a day of new hope and of promise for the future. The whole occasion also involves faith and love. Hallowed and celebrated for many generations, this day should influence our attitudes and outlook in the days to come. Right now is a good time to wish for all of you a season of joy and happiness and a period of enduring spiritual significance. Let us keep close this day, remembering the family and friends whom we cherish.

The birth of Christ started a completely new attitude in human relations. Our own Dr. Frank G. Slaughter, a distinguished physician-author and an eminent authority on Biblical history, has pointed out that the story of the Nativity of Jesus, in the second chapter of the gospel of St. Luke, and the account of the early church recorded in the Acts of the Apostles, were both written by a physician, St. Luke. In those days tension, unrest and insecurity existed, as now. There were constant attacks upon individual freedom and personal dignity. Luke found many of the answers, and wrote some convictions in his story of the life and teachings of Jesus Christ and of the dedicated followers who forgot self for the good of others.

Most physicians originally made the decision to become a member of the medical profession because of their interest in human problems and a spirit of dedication to the service of others. Most of them have in succeeding years lived up to this idealism. Every thoughtful practitioner of Medicine is well aware that a divine Providence created man and had a plan for him. Day after day in the practice of his profession one finds complexities in function and behavior that cannot be explained upon physical standards.

This should all be a source of encouragement and of inspiration to us now in our perplexities, amidst the threats to our personal security and freedom. The same principles apply now as in the days of St. Luke. Motivated by these principles, there is no reason for us to worry about the image of the profession or its status in the hearts of the public. We must respond, in these times of ceaseless challenge, with intelligence and courage. It is necessary to have faith in man, in ourselves and in God. Medicine has an obligation to be the faithful servant of mankind.

As Mary Lynn, founder of Mt. Holyoke College, told her students: "Trust in God, and do something!" In addition to scientific proficiency, we must have compassion for the patient and realization of our professional heritage. This personal relationship can be nurtured by service. But, above all, there must be an element of faith. In the Christmas story we are admonished to love God and to love our neighbor as ourself. With faith and hope and love, we have a star which can guide us in our attempts to preserve the traditions of the past and to make glorious plans for the future. So, in the words of the familiar Christmas carol of unknown authorship:

"God rest ye merry, gentlemen. Let nothing you dismay, For Jesus Christ, our Saviour, Was born upon this day, . . ."

1. Slaughter, Frank G.: The Beloved Physician, J. Florida M. A. 40:407 (Dec.) 1953.

Warren wopinelian



The Promise of Christmas

The cynic ridicules the idea that Christianity has exercised any influence on the moral progress of civilization and insists that any progress, which has been made, is due rather to evolutionary development of the race and scientic education. Even the followers of Christ often fail to realize the important influence on civilization which Christ's coming produced.

The birth of Christ was the inauguration of the most stupendous social and moral revolution that the world has ever witnessed. We, of the twentieth century, find it impossible to conjure up an accurate picture of conditions before Christ, because social institutions, which have become a part of our heritage, and moral principles, which seem based on our very nature, have been able to retain some of the redolence of Christianity, in spite of modern materialism and irreligion.

Scattered over the Greco-Roman world are noble ruins, whose stately architecture is the wonder and despair of modern craftsmen. These ruined temples are monuments to human degradation. Men went up to those temples, ostensibly to pray, and in the name of religion committed unspeakable crimes in honor of adulterous Jupiter, bloodthirsty Mars, and Venus, the degenerate mistress of lust. Men and women sprawled upon their faces to worship a cat, an ox, a crocodile, a painted pole, a statue of stone. Had they been content to prostrate themselves before the radiancy of the sun, or before the dignity of a stately oak, or before the magnificence of a mighty cataract, there would have been at least a semblance of esthetics in paganism, but vices became gods, and prayer became cruelty and lust. Is it any wonder that, with such religious ideas, slavery was the order of the day, marital infidelity the rule, greed and mercilessness the outstanding characteristics of the people?

Pagan philosophy was a reflection of pagan religion. Ignorant of God, pagan philosophers were ignorant also of the nature, the nobility, the destiny of man. Even Plato, the wisest of the ancients, was astray on the fundamental question of the soul's immortality. The Stoics considered God the cause of sin and corruption, as well as the source of virtue and life; for the Epicureans, eating and drinking, music, the theatre, pleasure—these were supreme wisdom. Cicero considered pride as the highest virtue, fear of God as insanity, prayer as useless and senseless. Slavery, infanticide, abandonment of the aged, domination of the weak by the strong, suicide to escape the burdens of life, were the results of this philosophy.

It was in the midst of such corruption that the song of the angels was heard on the hillside of Bethlehem. The story of that first Christmas night is the story of Love Incarnate. With the birth of Christ, God promulgated His edict of universal love and proclaimed the brotherhood of man. The birth of Christ was rebirth for the world, the foundation of a new kingdom wherein men are bound to God by love and to one another by charity for the love of God.

The fulfillment of Christ's mission has never been completely realized because His principles have never been fully accepted by men. The night He was born, the Savior found grudging hospitality from the world and has never received much more down the years. Conflicting forces were set in motion, whose constant struggles have frustrated the peace and happiness promised by the angels. Until men have become part of the revolution, inaugurated at Bethlehem, the promise of Christmas remains merely a dream.

Monsignor William J. Cusick St. Michael's Church Pensacola

Editor's Note: This is the third in a series of guest editorials appropriate to the season by leading ministers and rabbis published upon solicitation in the hope that physicians will find these messages a source of guidance and inspiration.

What Price Kildare?

With so much drama inherent in medicine, it is not surprising that novelists, playwrights and epic poets should find in it a source of inspiration for their work. In fact medical drama has come to rank second only to the man-to-man conflict of the Western story in the theatrical market place. Yellow Jack, Men in White and the like long ago proved the physician's popularity as a wearer of buskins, presaging the time when Doctor Kildare, Ben Casey, The Eleventh Hour and The Nurses would be among the most popular television programs, enthralling millions of viewers. In fact, medical shows probably move more merchandise and involve more advertising expense than the public spends for medical care, putting the medical profession in the position of possibly adding as much to the economy in goods as it receives in services, a double jolt to the GNP.

What is all this public interest doing to the physician's image—an increasingly important factor in the future of medicine?

There will be times, of course, when harassed doctors, pestered by patients in whom bizarre symptoms have developed since last night's Kildare episode, are strongly tempted to tell Ben Casey to go trephine a cranium. And with Christmas approaching, even the most tolerant of us can hardly help flinching at the prospect of watching another elderly Santa Claus totter through the Emergency Entrance of Blair General or daring to hope that the winsome heroine of The Nurses will stop tear-wringing long enough to string colored lights through Doctor Zorba's hair. But dramatically — and medically-absurd though these programs may often be, they are dominated by a strong idealistic current which is sadly lacking in many of today's relationships between the doctor and the public. They emphasize, too, the constant struggle for betterment of professional standards for which organized medicine receives far too little credit. True, this is often accomplished by overemphasis upon intraprofessional conflict; but the idealistic doctor or nurse-like the courageous lawman of the Westerns - always wins out. And even the orderlies are philosophers, surely an improvement over real life.

In a time when increasing numbers of young people are seeking college entrance and going on to graduate study, medical schools find themselves in the strange position of facing a dearth of high quality applicants. Whether medical television programs will arouse an increased interest in medical careers remains to be seen, for even the oldest of the programs have not been in favor long enough to have much of a carry-through effect upon medical entrance applications. But the chances are good that they are doing no harm to the public image of the medical and nursing professions or their future ranks.

What price Kildare? Perhaps not so high as it might seem to the physician frantically looking up a disease he hasn't even heard of since graduating from medical school. In fact, the handsome young doctor and his foil, Gillespie, may yet turn out to be blessings in disguise.

Frank G. Slaughter, M.D. Jacksonville

Editor's Note: This is the eleventh consecutive year The Journal has published a guest editorial in December by Dr. Slaughter, Florida's distinguished physician-author.

Electrocardiographic Interpretation

In this issue of The Journal there is a timely article of Dr. Henry J. L. Marriott entitled "Electrocardiographogenic Suicide and Lesser Crimes." The article is of particular interest to all physicians who read electrocardiograms in that Prinzmetal in 1956 estimated the average physician caring for cardiac patients sees 10 to 25 cases of "heart disease of electrocardiographic origin" per year. This observation reminds us of the adage, "At least do no harm to the patient." Dr. Marriott's paper emphasizes the importance of a complete history and physical examination in every patient in whom we make the diagnosis of heart disease. It is worth while to keep in mind that the laboratory data must be correlated with the history and physical examination, and unless the laboratory data corroborate the history and physical examination, it is a good idea to review the accuracy of the laboratory work. Although our patients have the impression that laboratory data are more important than the physician, we as physicians must never forget that laboratory data must be received in their proper perspective. Dr. Marriott is to be complimented on bringing to our attention the timely reminder that electrocardiographic interpretation is no better than the interpreter and it can do great harm to the patient if the findings are not properly interpreted.

CHARLES K. DONEGAN, M.D. St. Petersburg

Medical Research, Florida, Federalism and the United Fund

Dean Harrell's report on Medical Research at the University of Florida, published in the September issue of The Journal of the Florida Medical Association, is both timely and thought-provoking. This report plus the following true story should cause the Florida physician and citizen to pause and ponder concerning the objectives of medical education and research in the state and the nation.

Within the past few weeks an organizer of a relatively new voluntary health agency toured the state in an effort to expand his agency's chapter affiliations. The physicians with whom he had lunch on this occasion noted the literature of the organization implied that only a specific specialist could properly diagnose the disease and manage the patients concerned. One of the physicians pointed out that such patients are usually cared for by the internist, generalist or pediatrician; further, the specialty mentioned in the organization's literature was considered a subspecialty of medicine by most medical schools. The reply of this agency's representative was both startling and alarming. With apparent pride he informed these physicians that his organization was so influential with the federal government that it could force the dean of a medical school to establish a special professorial chair for this medical subspecialty, thereby giving it an equal status with the Department of Medicine, Surgery, and so forth. Medical schools failing to conform to such demands would find themselves cut off from further federal grants for research. One might laugh at the audacity of such a statement except for the increasing evidence that the tentacles of federalism are both ruthless and strangulating.

At the 1963 meeting of the American Medical Association's Council on Medical Education, several of the speakers expressed concern over the vast influence the federal government, via its medical research and fellowship grants, has on the trend of medical education. It was pointed out that federally sponsored medical research contributed greatly to the space program, yet at the present time had very little practical application for the practicing physician and the student of

A further discussion of this subject may be found immediately following this editorial in a "Letter" from George T. Harrell, M.D., of Gainesville, Dean of the University of Florida College of Medicine.

medicine. As a result of such programs, department heads and their medical staff all too frequently became so engrossed in the research aspect of the school that few qualified men were available for classroom lectures and bedside teaching. Compounding this problem, these research programs of necessity require that the various departments employ men primarily interested in the laboratory aspects of medicine, giving the medical student of today far too few teachers interested in the clinical aspects of the profession and their application to fellow citizens. Somehow the medical doctors of the nation, both educators and practitioners, must find a way to train adequately, through a balanced educational program, both the research scientist and the practitioner of medicine, able to meet adequately the needs of the people. If Florida's educational institutions are to remain free of federal control with its unscrupulous arm-twisting, the citizens of the state with the leadership of the physicians of Florida must support medical education and research, making every effort to avoid the use of federal funds for such projects. To do so will require a program designed to educate physicians, elected officials and citizens concerning these problems.

Florida has two medical schools. The state institution at Gainesville suffers as a result of the poor judgment of those responsible for choosing its location. While the state legislature can and should appropriate funds necessary to maintain this institution as one of the nation's finest, it is, however, unable to produce a population shift necessary to give this medical school the needed clinical material for an outstanding inpatient and outpatient teaching program. While the medical school at Miami is located in an adequately populated area, it unfortunately does not have access to the purse strings of the taxpayer and is therefore subjected to continuous economic problems. This is not a state problem; this is a national problem.

At the meeting of the AMA Council on Medical Education, medical schools were divided into the "have and have nots." During the discussions it was pointed out that the major portion of federal and nonfederal research grants went to the "have" schools located in Boston, New York

and Chicago. There was a marked decline in funds available for medical schools outside of these centers.

If Florida hopes to share in the economic growth of this nation in the coming decades, it must and can through the initiative, the ingenuity and the financial support of its elective representatives, citizens and professional scientists, develop and expand the scientific, educational and research facilities of the state. It courts only economic disaster, so apparent in several of the Southern states, by refusing to recognize these economic facts of life and failing to act accordingly.

The state administration, the Board of Control, the Council of One Hundred and others have gradually awakened to these facts. Unfortunately, the momentum obtained to date leaves much to be desired. The United Funds of several of the urban areas have recently become an ally in this direction. As Florida has become more industrialized, the United Fund has been requested by industry and others to live up to the name or purpose of this charitable solicitation—that is, a one campaign solicitation to meet all the charitable demands of the community. Complying with this request, many United Funds have once again included medical research in their program. It should be pointed out to physicians and citizens alike that the cost of such a campaign is less than 5 per cent with the result that 95 cents out of every dollar goes for the purpose for which it was contributed. This percentage is in sharp contrast to that of the voluntary health organizations whose administrative and campaign educational programs consume from 20 per cent to 60 per cent or more of the contributed dollar. It should be further pointed out to the physician and citizen that through the years the United Fund has budgeted a goodly percentage of its contributions to medical services. Home Nursing Services, Retarded Children's Programs, Mental Health, Marriage Counseling, the Care of the Unwed Mother and the adoption of her baby, have long been supported by the United Fund. As the United Fund, therefore, steps again into the field of medical research, it does not do so as a newcomer to this aspect of community responsibility.

Of necessity, at the beginning, contributions to medical research through the United Funds of Florida will be limited. By using the Florida Medical Foundation, however, which is set up by the Florida Medical Association to receive and distribute money for medical research and educa-

tion with no charge levied against such contributions, the full impact of these funds will be realized. Within the framework of the Florida Medical Foundation requests for research grants are carefully reviewed by a committee set up for this purpose. The Board of Directors of the Florida Medical Foundation is basically that of the Board of Governors of the Florida Medical Association. Meetings of the Florida Medical Foundation are held immediately following those of the Board of Governors of the Florida Medical Association, No charge, therefore, is levied against the Foundation for services or the travel expenses of its board members. The Executive Director of the Florida Medical Association serves as Executive Director of the Florida Medical Foundation at no charge. It should be anticipated that as this program expands, it would be necessary to hire a clerical secretary to handle the activities of the Foundation under the supervision of the nonpaid Executive Director. The salary incurred by such a job would be prorated against the various contributions received. It is my opinion that the United Funds of Florida would be in error in joining the Medical Research Program of the United Health Foundations, Inc. This opinion is based on the fact that the national association would levy a charge of 5 per cent or more against funds contributed within the state.

I would anticipate that a properly run medical research solicitation within the framework of the United Fund could and should in the near futurereach a sum of a quarter of a million dollars or more. This figure is based on the fact that Florida citizens are already contributing heavily to other voluntary health organizations unaware of the fact that these organizations do little or no research on their own but act as a collecting agency forwarding somewhat less than 40 per cent of the contributors' dollars for the purpose of medical research. The Florida Medical Association. The Florida Medical Foundation and the United Fund have the opportunity and responsibility to join, encourage and aid the state administration, the Board of Control, the Council of One Hundred, and others, in the development and expansion of the state's scientific research facilities both medical and nonmedical. Such a coalition, unhampered by problems of communication, and unchained by federalism, would guarantee the scientific and economic future of this state.

EDWARD L. COLE JR., M.D. St. Petersburg

Letters

Dear Sir:

The College of Medicine at the University of Florida is very grateful to the Editor of The Journal of the Florida Medical Association for an opportunity to reply to the editorial on "Medical Research, Florida, Federalism and the United Fund," appearing in this issue of The Journal.

The extent to which research funds enrich the academic program in medical schools and contribute to the support of the over-all educational program is often underestimated. In order to support a modern program in medical education, many medical schools have accepted research grants in the ratio of 1:1 to direct educational support. In some medical schools, the ratio of research funds is far higher. Grant funds are not used by the schools to replace funds from other sources, but research and training grants permit an increase in the number of faculty members available for teaching. Grants permit some faculty members to receive a part of their income from non-University sources. With federal funds, the amount of individual faculty support must be in proportion to the amount of time spent in prosecution of the research project.

I should like in the strongest possible terms to challenge the implication that any voluntary agency has sufficient influence to force a medical school to establish any specialized professorial chair. I should also like to challenge just as vigorously the statement that any voluntary agency can influence the federal government in its allocation of research grant funds. I have personally served on the National Advisory Health Council, on grant review and policy committees of the National Institutes of Health, and as a consultant to the United States Public Health Service over a period of years. I have also been the personal recipient of grants from the Public Health Service, Atomic Energy Commission, and the Office of Naval Research. I have never seen an attempt by any of these federal agencies, particularly the Public Health Service, to put pressure on medical schools to change their existing policies. As Dean of the University of Florida College of Medicine I would like to deny categorically that any attempt has ever been made by a governmental agency to influence the policies of this school, to force us to establish chairs, or to recognize sub-departments in any specialty since the establishment of this school.

The comments on the wisdom of placing the school in Gainesville deserve comment. The decision to place the school on the campus of the University was the result of long study by a number of experts from outside the State, as well as by educators and professional advisors within the State. The overriding consideration of the University environment was considered far to outweigh the advantages of a large population center. The experience since the establishment of the school in 1956 would not support the opinion that "poor judgment" was exercised in this decision. The number of patients needed for an educational program is usually greatly overestimated. The supply of patients required for teaching should be based on the number an individual medical student can see,

study thoroughly, and discuss adequately with his instructors. In the past, many medical schools, particularly those in large population centers, have assumed service loads which tend to swamp the educational program. The myth that an adequate supply of patients for teaching could never be achieved in Gainesville dies hard. At present, appointments for new patients in the Clinics must be made three to four weeks in advance, and for admission to the Teaching Hospital two weeks in advance because of the backlog of referrals from physicians in Florida.

The medical school at the University of Miami is receiving State help. The law passed by the 1951 Legislature enabled the University of Miami to establish a medical school, since it provided for a State subsidy based on the number of Florida residents admitted as full time students. At present the State contributes \$3,500 per year per student up to a maximum of 75 students in each class. This figure approximates \$1,000,000 annually. This sizable contribution by the State of Florida to medical education should be a source of pride to the people of the State and the Legislature should be complimented on its liberal and farsighted action.

Appropriations by the State and contributions from agencies such as the National Fund for Medical Education, the American Medical Association-Educational Research Foundation, United Funds, voluntary health agencies, and the new Florida Medical Foundation, would have to be increased very greatly over the present level of support to substitute for federal funds in order for the schools to continue the present level and caliber of educational programs. At the University of Florida, research grants are in the range of \$2,000,000 annually, approximately equal to State support. At the University of Miami, research grants are in the range of \$3,000,000 annually in a ratio of 3:1 to other support. Physicians and the general public should recognize these "economic facts of life" as the author of the editorial has pointed out and should actively support not only medical education, but higher education in general.

Sincerely,
GEORGE T. HARRELL, M.D., DEAN
UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE
GAINESVILLE

The following reply refers to a letter from David K. Davis, M.D., published in the November issue of The Journal.

Dear Sir:

Thanks for the copy of Dr. Davis' reply.

Using a lot of words, Dr. Davis seems to elevate laboratory function to something that it is not, and likely never will be. At least not at a price that our patients can afford to pay.

He surely has no such intent, but Dr. Davis is distinctly insulting to the physicians who use the services of his clinical laboratory. Unhappily, in a substantial number of instances, the practicing physician is much more aware of the reliability of the report of a blood count or glucose, etc., than is the pathologist technically in charge of the laboratory.

technically in charge of the laboratory.

He perhaps is clinging to the contention that the

practice of laboratory work is the practice of medicine. They have even succeeded in making this a state law in one state. This seems to me to be an extremely derogatory comparison. The distinguishing feature of the practice of medicine is the need for trained, highly-skilled, and intelligent *judgment*.

I don't want a technician using "judgment" on my laboratory results! I want a specific figure reported and if that figure is unreliable or subject to any interpretation having to do with technique, I want to be told. This is like saying that the technicians running the IBM machine in a bank are practicing banking. It is an important adjunct, and no more.

Finally, Dr. Davis would likely find that the editor of a medical publication is more careful about advertisers than he thinks. Certainly any time a responsible member points to any questionable aspect about a specific advertiser, the ad is not continued without careful investigation. But here we are dealing with a broadside against a whole group against whom there have been heard no professional complaints. The opinion presented by Dr. Davis is a philosophical one and moot, to say the least.

The motivation of people like Dr. Davis is obvious in the good intent expressed in his letter. Unfortunately, the outward appearances will suggest an underlying, and less commendable motivation.

If the pathologists make more of this than it deserves, someone outside the medical profession will really rock the boat. There is a much better approach than to quibble over ads in a technical publication.

Sincerely, W. E. MANRY JR., M.D., EDITOR IMPERIAL MEDICAL BULLETIN POLK COUNTY MEDICAL ASSOCIATION LAKE WALES



Association Meetings

Sixth Annual Conference County Medical Society Presidents and Secretaries Orlando, January 25 and 26, 1964

The conference sponsored annually by the Florida Medical Association for the incoming presidents and secretaries of its component county medical societies will be held at the Robert Mever Motor Inn in Orlando on January 25 and 26, 1964. The program is informative, diversified and stimulating; it is planned to assist the county society officers at a time when they are taking office for the new year. For five years these meetings have evoked increasing interest each year, and it is anticipated that this sixth annual meeting, held in Orlando instead of Jacksonville as previously, will attract a record attendance. It will be to the advantage of every county society to be represented by its president and secretary and as many other officers as possible.

At the opening session on Saturday afternoon, the program covers the national scene and includes four panel discussions on indigent care and medical services, medical economics, the legislative program, and Association-sponsored programs. Round table discussions followed by open discussion of county and state programs feature the Sunday morning session.

SATURDAY AFTERNOON, JANUARY 25, 1964

1:00 p.m. Registration

Presiding—Warren W. Quillian, M.D., President

1:15 p.m. Remarks of the President—Warren W. Quillian, M.D.

"The National Picture and AMA Progress" 1:30 p.m.

Ernest B. Howard, M.D., Asst. Exec. Vice President, A.M.A.

2:00 p.m. Indigent Care and Medical Services Panel—Charles R. Sias, M.D., Moderator, Chairman, Council on Medical Services

Current Programs (HSI-PAR-MAA)—Nelson Zivitz, M.D., Chairman, Committee on Indigent Care

Improvements Needed—H. Phillip Hampton, M.D., Chairman, Council on Legislation

and Public Agencies Medical Service Programs:

Child and School Health—Irving E. Hall Jr., M.D., Chairman, Committee on Child

Mental Health—Zack Russ Jr., M.D., Chairman, Committee on Mental Health Public Health-Wilson T. Sowder, M.D., State Health Officer

Ouestions and Answers

3:00 p.m. Coffee and Coke Break 3:10 p.m. Medical Economics Panel

Blue Shield-W. Dean Steward, M.D., President, Blue Shield

Utilization and Review Committees—David J. Lehman Jr., M.D., Member, Committee on Commercial Health Insurance

Workmen's Compensation and Medicare—Henry J. Babers Jr., M.D., Chairman, Committee on Fee Schedules

Questions and Answers

4:00 p.m. Legislative Program Panel

National Legislative Program and Operation Hometown—Joseph C. Von Thron, A.M.A. Speakers Bureau

State Legislative Program—George S. Palmer, M.D., Chairman, Committee on State Legislation

Questions and Answers (Panelists plus Mr. Al D. James and Mr. Richard Nelson)

5:00 p.m. FMA Sponsored Programs Panel

Professional Liability, Disability, etc.—Robert E. Zellner, M.D., Immediate Past

President

FMA Investment Plan-Floyd K. Hurt, M.D., Secretary-Treasurer

6:30 p.m. Social Hour 7:30 p.m. Buffet Dinner

SUNDAY MORNING, JANUARY 26, 1964

Presiding—Samuel M. Day, M.D., President-Elect

9:00 a.m. Potpourri Round Table Discussions for county medical society presidents and secretaries (Moderator at each table will change—participants remain at same table) (20 minutes each table)

1-Indigent Care Programs-H. Phillip Hampton, M.D. and Simon D. Doff, M.D.

2-Medical Economics-Henry J. Babers Jr., M.D. and Mr. N. G. Johnson

3-Legislation-George S. Palmer, M.D. and Mr. Al James

4-Medical Services-Charles R. Sias, M.D. and Mr. Eugene L. Nixon

5-Management and Administration-Jere W. Annis, M.D. and Mr. W. Harold Parham

10:45 a.m. Questions and Answers-Moderators

11:00 a.m. Coffee and Coke Break

11:15 a.m. Open Discussion of County and State Programs

1:00 p.m. Adjournment of Conference

Deaths

Ames, Allen Monti, Pensacola; born in Ocean Springs, Miss., on Jan. 24, 1888; Tulane University School of Medicine, New Orleans, 1912; served an internship at Charity Hospital of Louisiana, New Orleans, from 1912 to 1914; entered the private practice of surgery and general medicine in Pensacola in 1914 and continued in active practice there for 46 years; was a veteran of World War I, serving in the Army Medical Corps from 1917 to 1919 with the rank of captain, was several times president of the Escambia County Medical Society; held membership in the American Medical Association and the Southeastern Surgical Congress; died June 18, aged 75.

Chappell, Jean Rocher, Orlando; born in Webster County, Georgia, on April 11, 1898; Emory

University School of Medicine, Atlanta, Ga., 1921; interned at Piedmont Hospital, Atlanta, and completed a two year surgical residency at Lexington Avenue Hospital in New York City in 1924; practiced general surgery in Orlando for 40 years; was a veteran of World War II, serving as chief of surgery at MacDill Air Base Hospital, Tampa, Jefferson Barracks Hospital, St. Louis, Ninth Station Hospital, Guadalcanal, and 233 General Hospital, Okinawa; left the service with the rank of colonel to resume practice in Orlando: devoted much time and effort to the office of Deputy Director for Medical Services of Civil Defense, to which he was appointed by Governor LeRoy Collins; had served the Orange County Medical Society as president, secretary and treasurer, and chairman for a decade of its Civil Defense and Disaster Committee; was a former member of the Board of Governors of the Florida Medical Association and also had served as chairman of its Committee on Scientific Work, Advisory Committee to Selective Service and Committee on Civil Defense and Disaster; was a past president of the Florida Association of General Surgeons; held membership in the American Medical Association, Southeastern Surgical Congress, American College of Surgeons, International College of Surgeons and World Medical Association; died August 21, aged 65.

Halton, Joseph, Sarasota; born in St. Helens, Manchester, England, on Jan. 9, 1881; Miami Medical College, Cincinnati, Ohio, 1906; served an internship at Speers Memorial Hospital, Dayton, Ky., and engaged in extensive postgraduate training across the years in leading medical centers of the United States and Europe; located in Sarasota in 1907 and practiced general medicine and surgery there for 56 years; owned and operated the Joseph Halton Hospital in Sarasota; was a past president of the Manatee County Medical Society; honored by that society on completing 50 years of medical practice in the community, he received on that occasion the first Life Membership Certificate issued by the Florida Medical Association, initiating that custom by the Association; was among the first physicians in Florida to use insulin with success; held membership in the American Medical Association and the International College of Surgeons; died June 17, aged 82.

Merritt, John Webster, Jacksonville; born in Gainesville in August 1906; Johns Hopkins University School of Medicine, Baltimore, Md., 1933; after serving an internship at Maryland State Tuberculosis Sanitorium, was house officer at Boston City Hospital, Boston, Mass., from December 1933 to July 1935 and then served a residency at Riverside Hospital, Jacksonville; engaged thereafter in the private practice of internal medicine and cardiology in Jacksonville for 27 years; was a veteran of World War II; was a well known medical historian and author of "A Century of Medicine in Jacksonville and Duval County;" served for three years as editor of the Bulletin of the Duval County Medical Society, was chairman and editor-historian of the Centennial Committee of "Duval County Medical Society Hundredth Birthday 1853-1953," and also was editor and chairman of the Writers Committee for "The Jacksonville Story; Fifty Years of Progress 1901-1951;" was from 1948 to 1961 Assistant Editor of The Journal of the Florida Medical Association; held membership in the American Medical Association, Southern Medical Association, American Society of Tropical Medicine and Trudeau Society, was a fellow of the American Heart Association and a member and former chairman of the Medical Advisory Committee to the Florida Heart Association, and was a fellow of the American College of Physicians and the American College of Cardiology; died following a long illness on October 4, aged 57.

Simmons, Eugene Douglas, Jacksonville; born in Jacksonville on May 25, 1907; Tulane University School of Medicine, 1935; served an internship at Long Island Hospital, New York City, and in 1938 completed a two year residency at Worcester City Hospital, Worcester, Mass.; served during World War II as a flight surgeon in the Navy from 1942 to 1946, ending his military service with the rank of lieutenant commander; engaged in the practice of general medicine and surgery in Jacksonville for a quarter of a century; held membership in the American Medical Association, Florida Academy of General Practice, American Academy of General Practice, Florida Heart Association, Florida Diabetes Association and Industrial and Railway Surgeons Association: died October 17, aged 56.

Vinson, Willie J., Tarpon Springs; born in Bonaire, Ga., on Sept. 10, 1887; Atlanta College of Physicians and Surgeons, Atlanta, Ga., 1911; interned at Natchez Hospital, Natchez, Miss., and Florida State Hospital, Chattahoochee, engaged in the general practice of medicine in Tarpon Springs from 1914 to 1923; after graduate study at Harlem Eye and Ear Hospital and Knapp Memorial Eye Hospital in New York, practiced ophthalmology and otolaryngology in Miami from 1924 to 1952 and in Tarpon Springs from 1952 to 1959 when ill health brought retirement; served in the Army Medical Corps with the rank of captain in World War I and colonel in World War II; held membership in the Florida Medical Association for 51 years and was a member of the American Medical Association, Southern Medical Association, Florida Society of Ophthalmology and Otolaryngology and Pan American Ophthalmological Society; died September 17, aged 76.



The Lady Governors of the Old Men's Home at Haarlem

FRANS HALS, 1580/81-1666

In Geriatrics...

METAMUCIL® Provides Bland Smoothage

brand of psyllium hydrophilic mucilloid

The tendency of the elderly to subsist on low-residue foods often is a prime cause of bowel sluggishness. Adequate fecal content is necessary to maintain normal colonic function, since intracolonic distention is nature's method of stimulating reflex peristalsis.

Metamucil, therefore, fulfills a basic function in the treatment of geriatric constipation. It both softens hard, dehydrated fecal concretions and adds smooth, nonirritant, easily compressible hydrophilic bulk.

Metamucil applies a physiologic principle to correct constipation naturally.

Average Adult Dose: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. To Metamucil powder, a re-

fined, purified and concentrated psyllium hydrophilic mucilloid, an equal amount of dextrose is added as a dispersing agent. Each dose of the powder furnishes a negligible amount of sodium and 14 calories. To the mucilloid in Instant Mix Metamucil citric acid, sodium bicarbonate and mild flavoring are added. Each dose of Instant Mix Metamucil furnishes 0.25 Gm. of sodium and 3 calories. Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

G. D. SEARLE & CO.

CHICAGO, ILLINOIS, 60680

Research in the Service of Medicine

SNAKEPROOF BOOTS

TESTED AND ENDORSED By ROSS ALLEN

Here is the perfect gift for Christmas or any occasion. For peace of mind and safety when hunting, fishing, camping or any outing. We have your size. Also venoms, animal blood, books and free price lists.

> **RED WING BOOTS \$39.95** POSTPAID

Merry Christmas **ROSS ALLEN** Silver Springs, Fla. 32688



News

The author of the article on "Dermatology" published on page 380 of the November issue of The Journal was incorrectly listed as Dr. Morris Waisman of Tampa. Credit should have been given to the Scientific Exhibit Committee of the Florida Society of Dermatology. The Journal apologizes for this error.

The Federal Trade Commission has medical officer vacancies on its scientific staff for physicians interested in career service. Information may be obtained from George Dobbs, M.D., Associate Chief, Division of Scientific Opinions, Federal Trade Commission, Washington 25, D. C.

Dr. Richard T. Smith of Gainesville, Professor and Head of the Department of Pediatrics at the University of Florida College of Medicine, has received the E. Mead Johnson Award for his research in the immunological processes.

Dr. James H. Ferguson of Miami, Chairman, Department of Obstetrics-Gynecology, University of Miami School of Medicine, has been presented a citation by the World Medical Association for his film, "Lymphangiography in Gynecologic Cancer."

Announcing The Twenty-Seventh Annual Meeting of THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters — Roosevelt Hotel

March 2, 3, 4, 5, 1964

GUEST SPEAKERS

Nicholas M. Greene, M. D., New Haven, Conn. Anesthesiology Adolph Rostenberg, Jr., M. D., Chicago, Ill.

Autoph Rostenberg, Jr., M. D., Chicago, In Dermatology
Arthur P. Klotz, M. D., Kansas City, Kans. Gastroenterology
J. Roswell Gallagher, M. D., Boston, Mass. General Practice

General Practice
Roger B. Scott, M. D., Cleveland, Ohio
Gynecology
George R. Herrmann, M. D., Galveston, Tex.
Internal Medicine
William C. Thomas, Jr., M. D., Gainesville, Fla.
Internal Medicine
John B. Reckless, M. D., Durham, N. C.
Neuropsychiatry
Robert A. Cosgrove, M. D., Jersey City, N. J.
Obstetrics

Roy O. Scholz, M. D., Baltimore, Md. Ophthalmology Otto E. Aufranc, M. D., Boston, Mass. Orthopedic Surgery Paul H. Holinger, M. D., Chicago, Ill. Ottolaryngology Paul H. Holinger, M. D., Chicago, III.
Otolaryngology
Paul K. Lund, M. D., Seattle, Wash.
Pathology
Margaret Lyman, M. D., New York, N. Y.
Pediatrics
Paul M. D. Momphis, Tonn David S. Carroll, M. D., Memphis, Tenn. Radiology C. Barber Mueller, M. D., Syracuse, N. Y.

Surgery
Lloyd M. Nyhus, M. D., Seattle, Wash.
Surgery
John K. Lattimer, M. D., New York, N. Y. Urology

The Lawson Memorial Lecture: Isidor S. Ravdin, M. D., Philadelphia, Pa. Lectures, symposia, clinicopathologic conferences, round-table luncheons, Medical motion pictures, technical exhibits and entertainment for visiting wives. (All-inclusive registration fee - \$20.00)

CLINICAL TOUR TO EUROPE VIA LISBON, MADRID, ROME, VIENNA, BERLIN, AND PARIS.

Leaves March 7 via air; returns March 28, 1964 For further information write Secretary, N. O. Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, La. 70112

Volume 50/Number 6

Introducing A New Sulfonamide

A POTENT, LOW DOSAGE SULFONAMIDE DISTINGUISHED BY ITS INCREASED MARGIN OF SAFETY.

AN INCREASED MARGIN OF SAFETY ...



The need for critical dosage adjustment to avoid toxic manifestations, is minimized when the sulfonamide chosen is SULFABID (brand of sulfaphenazole).

With SULFABID (sulfaphenazole), effective blood and plasma levels are achieved with a convenient twelve-hour dosage schedule, yet its urinary solubility and rate of excretion combine to provide a high degree of safety with minimal risk of excessive drug accumulation. In order to demonstrate this high degree of safety, Essellier and co-workers (1), personally took 25 grams daily for five days . . over six times the recommended therapeutic maintenance dosage level without experiencing

intolerance. SULFABID (sulfaphenazole) has been critically evaluated in the treatment of thousands of patients throughout the western world, more than one-third of whom were infants and The results have established that children. SULFABID (sulfaphenazole) is well tolerated, and that in appropriate dosage it produces satisfactory therapeutic effects.
SULFABID (sulfaphenazole) is indicated in

a wide variety of infections caused by sulfonamide-susceptible bacteria, Abscesses, Bronchitis, Cellulitis, Cystitis, Furunculosis, Otitis media, Pharyngitis, Prostatitis, Pyelonephritis, Sinusitis, Tonsillitis,

Urethritis and wound infections. An informative brochure . . . with clinical findings and bibliography is available from your Physicians Products Medical Service Representative or by mail request.

THESE CASE STATISTICS BASEO UPON 33 PUBLISHEO REPORTS OF THERAPEUTIC RESPONSE TO SULFABIO * (Sulfaphenazole)

Indications	No. of	Res	ponse*
	Patients	Recovered	None
Biliary tract infections	24	18	6
Bronchitis	233	190	21
Pharyngitis, laryngitis	185	155	16
Other upper respiratory infections	261	199	32
Dysentery, enteritis	49	46	3
Febrile abortion	39	32	7
Pelvic Inflammatory disease—adnexiti endometritis, parametritis, etc.	s. 5 2 3	484	6
Lymphadenitis, sinusitis	32	28	3
Otitis	159	116	16
Puerperal infections	140	54	55
Skin diseases—furunculosis. pyoderma, erysipelas, etc.	78	54	8
Surgical infections	206	199	7
Tonsillitis	125	122	1
Urogenital infections— prophylaxis therapy	269 989	222 723	58 139
Miscellaneous	393	292	71
*9% unreported	3705	2934 79%	449 12%
(1) Essellier, A. F., H. Hunsiker and R	. Goldsand; 1	Ibid 88:813,	1958.

Contraindications

Contraindications

Sulf-ABID (Sulfaphenazole) is contraindicated in patients known to be sensitive to sulfonamides. Like most sulfonamides and certain other drugs, its use is a'so inadvisable in treating premature infants and in full-term infants for the first week of life due to underdeveloped enzyme systems and liver and renal function. For the same reasons, SULFABID (Sulfaphenazole) should be used with caution

Precautions

Precautions
While the reported incidence of reactions to SULFABIO (Sulfaphenazole) is low, the usual precautions in sulfonamide therapy should be observed, Including maintenance of adequate fluid intake. In the event of headache, nausea or vomiting, dosage should be reduced or discontinued; if urticaria, rash, fever or hematuria occur, the medication should be discontinued. When SULFABIO (Sulfaphenazole) is used intermittently or for prolonged periods, blood counts should be performed regularly to detect the possible occurrence of blood dyscrasias. Administration of the drug should be stopped Immediately if alterations are observed in the hematopoietic system. Patients with impalred renal function should be followed closely in order to avoid excessive drug accumulation.

Dosage:

Dosage: SULFABIO (Sulfaphenazole) is administered orally as tablets or as a suspension twice daily for five to seven days or until the patient remains asymptomatic for 48 hours.

Initial Oose Every 12 Hrs. Thereafter

Aduits: Moderate to severe infections— 6 tablets (3 gm.) or 2 tablespoonfuls

2 tablets (1 gm.) or 2 teaspoonfuls (10 cc.) of Suspension

2 tablespoonrus
(30 cc.)
of Suspension
Mild or urinary tract
infections—
4 tablets (2 gm.) or
4 teaspoonfuls (20 cc.)
of Suspension of Suspension Children: 30 mg./lb. 1 teaspoonful of

2 tablets (1 gm.) or 2 teaspoonfuls (10 cc.) of Suspension

15 mg./lb. ½ teaspoonful of Suspension or ½ tablet per 17 lbs. Suspension or 1 tablet per 17 lbs. Incidence of Side Effects

In extensive clinical experience, the over-all incidence of side effects with SULFABIO (Sul-aphenazole) has been low. Side effects were mainly limited to complaints of stomach upset and nausea, and these were mild and of short duration. Supplied

*Tablets: 0.5 Gm., bottles of 50, 250, 1000. *Suspension: 0.5 Gm. (500 mg) per 5 cc. (teaspoon), bottles of 50 cc. (non-spillable, with a dropper marked for ½ and ½ teaspoon), and 1 pint.



New Members

The following doctors have joined the State Association through their respective county medical Societies.

Active

Bolton, Joseph R., Brooksville
Bradley, Charles F., New Smyrna Beach
Brookins, James O., (Col.) Tampa
Creighton, J. Burns Jr., Tampa
Dodd, Paul Melton, Daytona Beach
Flipse, Robert C., Miami
Guttman, Benjamin C., Clewiston
Harris, Robert S. Jr., Coral Gables
Hewitt, James C., Tampa
Holley, John C. Jr., Milton
Kendall, Colin H. G., Fort Pierce
Kraus, Frederick O., Palm Harbor
McGowan, Jack L., Fort Pierce
Marlowe, James M., Port Richey
Mathews, Hurschell F., Tampa
Miethke, Richard P., St. Augustine
Myers, William G., Hobe Sound
Nemser, Abraham, Miami Beach
Pooser, Francis S., Melbourne
Punches, James G., Vero Beach
Thompson, Jasper F. HI, Rockledge
Tsavaris, Louis J., Tampa
Unger, Pat B., Melbourne
Westmark, Edward R., Jay
White, M. Jeffrey, Tampa

Associate

Albornoz, Leonidas, Miami Alexanian, Anna S., Coral Gables Bell, Jerry S., Hollywood Bernstein, Stuart P., Orlando Bocles, Jose S., Miami Bolton, Patricia O., Pompano Beach Bonura, Charles M., Fort Lauderdale Brown, Fred D., Miami Buehrig, Milton W., Lake Worth Calabrese, Anthony S., Orlando Calabrese, Anthony S., Orlando
Calhoon, Jay W., Fort Lauderdale
Cannon, Stanley J., Miami
Clark, Julian A., Miami
Dexter, Charles S., Orlando
Feng, Tscheng S., Lantana
Field, Roddy A. III, Panama City Fitzgerald, Maurice D., Miami Fleming, William C., Coral Gables Franzino, Arthur F., Miami Gant, George A., Kissimmee Garner, Stanley G., Miami Glantz, William M., Hollywood Glattauer, Alfred, Perrine Gold, Hillard, Miami Beach Greenberg, Samuel I., Miami Gullatt, Victor Reid, St. Petersburg Hardy, Douglas F., Orlando Harris, Marvin, Miami Helfman, Richard J., Coral Gables Hiribarne, Pedro F., Orlando Hoffmeister, William E., Winter Park Holly, John H. Jr., Miami Johnsen, David S., Fort Lauderdale

increases
blood flow
to the brain
in the
"senility syndrome"
associated
with
cerebrovascular
insufficiency



Judd, Allyn F., Delray Beach Kalbac, Joseph J., Miami Katz, Evan, Miami Kiszka, Edward F., Delray Beach Kornhaber, Arthur, Gainesville Liebeskind, Robert S., Miami Luxenberg, Kenneth, Miami McCollough, Newton C., III, Miami Madison, James B. III, Miami Magoon, Robert C., Miami Beach Matz, Martin H., North Miami Beach Medow, Aaron, Miami Beach Molinet, Roland K., Fort Lauderdale Moya, Frank, Miami Mutter, Charles B., Miami Myers, John E., Miami Nagel, Eugene L., Miami Osborne, Warren R., Fort Lauderdale Owens, George M., Gainesville Podis, Alan D., Hollywood Putter, Pierre J., Bay Harbor Island Romaguera, Raul, Boynton Beach Ruiz, Luis, Miami Sandberg, James R., Coral Gables Slonim, Roberte R., Miami Smith, Stanley B., Miami Stuart, James Alvin, Miami Tanner, John R., North Miami Tellefsen, Kenneth B., Orlando Truppman, Edward S., North Miami Beach Tufts, Thomas W., Opa Locka Vacek, Abraham J., Orlando Van Dyke, Rufus O. Jr., Orlando Varela, Fernando L., Riviera Beach Vaughn, Darrel L., Deerfield Beach Walls, William L., Pompano Beach Weinfeld, Albert, Miami

Don't Make a Move Until You Inspect



Miami Beach's

Meridian

BUILDING

A PRESTIGE ADDRESS with custom-built facilities for the Medical Profession

Here are a few of its outstanding features:

LOCATED in the finest Medical Area in all of Miami Beach Meridian Ave. at 17 Street • JE 4-4757



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems. 1-3

43% increase in cerebral blood flow4

In patients with cerebrovascular insufficiency, Eisenberg⁴ measured a 43 percent increase in blood flow in the brain following administration of Arlidin (nylidrin HCl) orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

Winsor and associates³ found Arlidin (nylidrin HCI) "of particular value clinically in relieving some of the symptoms of cerebral vascular insufficiency (vertigo, lightheadedness, mental confusion, diplopia)."

arlidin[®] BRAND OF NYLIDGE IN THE I

SUMMARY: Indicated whenever an increase in blood supply is desirable in circulatory insufficiencies of the extremities, brain, eye and ear. Use with caution in the presence of a recent myocardial lesion, severe angina pectoris and thyrotoxicosis. Contraindicated in acute myocardial infarction.

REFERENCES: 1. Madow, L.: Penn. M. J. 62-861, June 1959 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Labs., division . 800 Second Avenue, New York 17, N. Y.

WANTED: General Practitioner, Internist, Pediatrician, to join surgeon in new clinic. Exciting growth enterprise in finest Cape Canaveral location. Arrangements open. Write 69-484, P.O. Box 2411, Jacksonville, Fla.

UNUSUAL OPPORTUNITY FOR DOCTOR ON EAST COAST: Superb location. Modern building. Air conditioning, heat, janitor service, ample parking. Box 2303, Jacksonville, Fla., Phone EL 3-8127.

WANTED: Pediatrician, ENT, Internist and Dermatologist for new medical building ready Feb. 15. Adjacent to bospital in beautiful location on Gulf of Mexico. Fine practice opportunity. Write 69-510, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER: New professional office for rent Cocoa, Fla. 1,200 sq. ft. floor space. Designed for physician. Wired for X-ray. Nicely paneled personal office and waiting room. 5 examining rooms each equipped with wash basin. Laboratory. Central air-conditioning system with reverse cycle for central heat. Adjoining new upper class 30 unit furnished apartment complex. Ground floor corner location with exterior professional design. Ample parking. 3 separate entrances. Choice location in fastest growing county in U.S. For information call A. A. Annis, Newton 6-1872 or write P.O. Box 6, Cocoa, Fla.

MEDICAL OFFICE AVAILABLE: Unusual opportunity for GP or specialist in Miami Beach. Call Jefferson 1-1246 or contact: Dr. Leonard Sakrais, 1500 Bay Rd., Miami Beach, Florida.

WANTED: Pediatrician for association with two obstetricians. Office space, basic equipment and guaranteed income are available for an acceptable man. Write 69-551, P.O. Box 2411, Jacksonville, Fla.

PRACTICE FOR SALE: Excellent general practice and equipment, Fort Myers proper, established 17 years same location. Contact: Curtis R. House, M.D., 2203 McGregor Blvd., Fort Myers, Fla.

WANTED: Associate by busy general practitioner. Excellent remuneration to start with full partnership after one year. No investment necessary. Write 69-552, P. O. Box 2411, Jacksonville, Fla.

LOCUM TENENS: Experienced General Practitioner desires locum tenens for month of January. Has Florida license. Write 69-554, P.O. Box 2411, Jacksonville, Fla.

AVAILABLE: For \$90 enjoy professional suite of 4 rooms air-conditioned in Medical Arts Building, 503 W. Platt, Tampa. Phone 251-1600.

PEDIATRICIAN WANTED: Florida license. \$1000 minimum monthly guarantee first 6 months or 40% of income. Second 6 months 45% and full partnership after one year. Large income now. May be expected to increase considerably with complete coverage of vacation and days off. Write 69-547, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER wanted for full time group practice in Central Florida in Fall of 1963. This is a large established practice in pleasant community. Please send resume to 69-543, P.O. 2411, Jacksonville, Fla.

WANTED: Nose and throat man, Obstetrician, Dermatologist, Internal Medicine. Arrangements open. Growing community. Phone John O. Rao, M.D. 847-2833, Kissimmee, Fla.

INTERNIST: Miami general surgeon expanding practice forming group. Salary \$250. weekly then progressive partnership. Building new medical office. State all particulars first letter. Write 69-558, P.O. Box 2411, Jacksonville, Fla.

OFFICE SPACE FOR RENT: Medical suite, approximately 600 sq. ft. in separate consultation, two treatment and laboratory rooms. Share secretary and reception room. New professional building, excellent furnishings. Suitable for specialty or general practice. Clarence H. Schilt, M.D., 2161 McGregor Bldg., Ft. Myers, Fla.

OPHTHALMOLOGIST WANTED: East Coast city, to associate in large established practice. Board certified or eligible. Write 69-555, P. O. Box 2411, Jacksonville.

WANTED: General Practitioner for Clinic-Hospital. Salary open—plus bonus. Write 69-535, P.O. Box 2411, Jacksonville, Fla.

GENERAL SURGEON: Board qualified Association, Miami general surgeon expanding practice forming group. Salary first year \$250. weekly then progressive partnership. Building new medical office. State all particulars first letter. Write 69-557, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER: Miami general surgeon expanding practice forming group. Salary \$250. weekly then progressive partnership. Building new medical office. State all particulars first letter. Write 69-559, P.O. Box 2411, Jacksonville, Fla.

PRACTICE FOR SALE: Thriving, long established general practice including records, equipment and offices. Excellent Southside Jacksonville location. Write 69-556, P.O. Box 2411, Jacksonville, Fla.

ATTENTION PSYCHIATRISTS AND M.D.'s: tbat are looking for semi-retirement with an opportunity for excellent income. We have an ideal location for rest and/or recuperating home. For further information call 399-2214, Boca Raton, Fla. after 7 p.m. or write 69-560, P.O. Box 2411, Jacksonville, Fla.

INTERNIST OF GENERAL PRACTITIONER: Physician established here for 10 years in a rapidly growing community wishes to bave another physician to share completely furnished 1,500 sq. ft. office space, equipped with x-ray, EKG, Diathermy, etc. Write to POMPANO BEACH MEDICAL BLDG., 2701 Atlantic Blvd., Pompano Beach or call WH 1-2420.

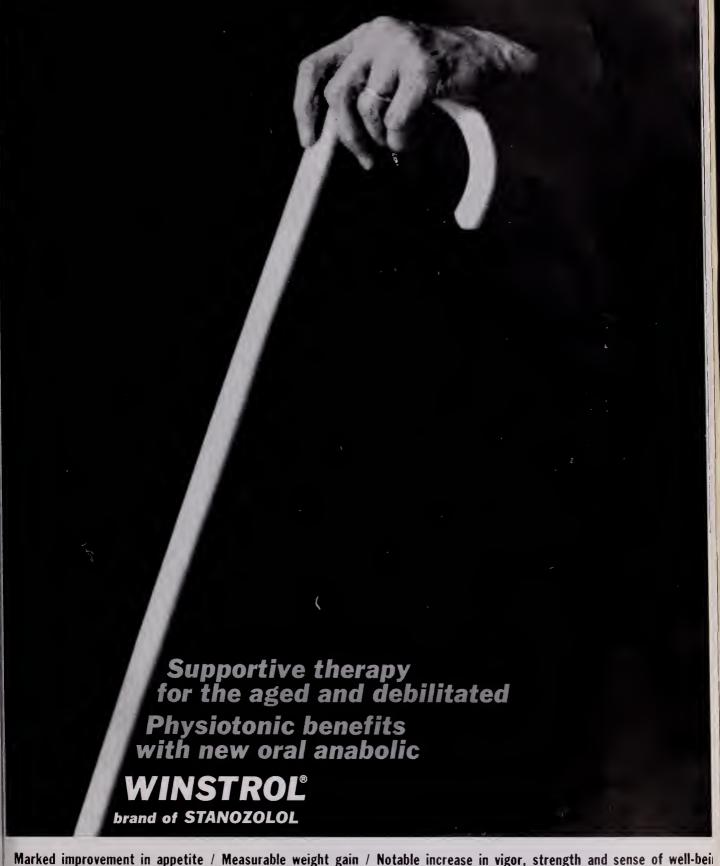
ESTABLISHED DOCTOR DIED: Fully equipped office and equipment available. Sell at cost and goodwill. For information contact: Thomas W. Sweet, Trust Officer, The Citizens and Southern National Bank, P.O. Box 4899, Atlanta 2, Ga., or phone Atlanta Area Code No. 404 - JA 5-3811, Ext. 835.

GENERAL PRACTITIONER WANTED: Join actively growing General Practice, Dade County, Florida. Salary \$18,000 first year; \$24,000 second year; partnership third year. No investment needed. Resume to 69-561, P.O. Box 2411, Jacksonville, Fla.

WANTED: An Internist to join three man group practice in internal medicine in southeastern section of the state. First year guarantee \$15,000 with limited partnership and eventual full partnership. Write 69-562, P.O. Box 2411, Jacksonville, Fla.

FORT LAUDERDALE SPECIALISTS' SUITES: One remains for rent. New quality colonial building planned, with M.D. and D.D.S. In front Holy Cross Hospital off Federal Highway. Write M.D., 1601 E. Broward Blvd., Fort Lauderdale, Fla.

FOR RENT: Complete office, seven rooms, water-front Doctors Building. \$225. per month. Air-conditioning, heat, bot water, janitor service. Downtown. Free parking for patients. Contact S. J. Wilson, M.D., 309 N.E. River Drive, Fort Lauderdale, Florida.



Marked improvement in appetite / Measurable weight gain / Notable increase in vigor, strength and sense of well-being

New anabolic Winstrol combines highest potency* with outstanding tolerance in an economical oral tablet. Employed adjunctively, its physiotonic benefits are evident in the management of a variety of patients: the geriatric; the post operative; the weak; the debilitated with chronic or malignant disorders. Winstrol reverses tissue-depleting processes, restores a positive metabolic balance, rebuilds body tissue while it builds strength, builds confidence and restores a sense of well-being.

Usual Adult Dose: I tablet t.i.d. Before prescribing, consult literature for ad tional dosage information, possible side effects and contraindications. Supplied: 2 mg. tablets. Bottles of 100.

With Winstrol, patients look better...feel stronger because they are stronger!

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

THE DUVALL HOME for RETARDED CHILDREN

A home offering the finest custodial care with a happy home-like environment. We specialize in the care of infants, bed-ridden children and Mongoloids.

For further information write to

MRS, A. H. DUVALL GLENWOOD, FLORIDA

Patronize Your

Independent X-ray Dealer

He'll be around when you need him

BOB WAGNER X-RAY

P. O. Box 8161 Jax 11, Florida RA 4-3434.



P. L. DODGE MEMORIAL HOSPITAL

formerly

MIAMI MEDICAL CENTER

M. G. ISAACSON, M.D. Medical Director and President

1861 N.W. South River Drive Phone 379-1448

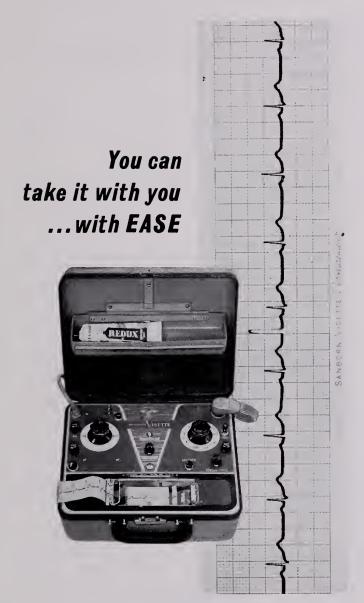
A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including — Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities.

Information on request Member NAPPH and American Psychiatric Assn.



compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy. brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.





Here is a modern, clinicallyaccurate ECG of proven usefulness in thousands of practices — yet **light and compact enough** for even a slight nurse or technician to carry with ease.

Complete with all accessories, the Sanborn Model 300 Visette® electrocardiograph weighs only 18 pounds, is as compact as a ladies overnight case. Fully diagnostic, permanent 'cardiograms in all standard leads are recorded by heated stylus on inkless Permapaper®, for immediate interpretation. Simple paper loading, pushbutton "grounding", space for all accessories in the cover are a few of the Visette's convenience features. Your nearby Sanborn Branch Office or Service Agency will be happy to provide a demonstration or 15-day No-Obligation Trial of this modern, lightweight, moderately-priced 'cardiograph. Call your Sanborn man at your convenience.



SANBORN COMPANY

MEDICAL DIVISION Waltham 54, Mass.

A Subsidiary of Hewlett-Packard Campany

MIAMI Branch Office 2907 N. W. 7th St., 305 635-6461
St. Petersburg Resident Representative
337 22nd Ave. N., 862-3229

Jacksonville Resident Representative
2720 Park St., 384-3453

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary ar venaus bleeding presents a problem. KOAGAMIN has an outstanding safety recard -- in 25 years af use no repart of an untoward reaction has been received; hawever, it should be used with care on patients with a predisposition

ta thrambasis.



parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malanic acid, phenal 0.25%; sodium carbonate as buffer. Complete data with each 10cc vial. Therapy chart on request.



(Talliam) CHATHAM PHARMACEUTICALS, INC.

Newark 2, New Jersey

Distributed in Canada by Austin Labarataries, Ltd. . Paris, Ontario

CONVENTION PRESS

218 W. CHURCH ST. JACKSONVILLE, FLORIDA

QUALITY **BOOK PRINTING PUBLICATIONS** BROCHURES

W HATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine quality work-and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



JACKSONVILLE

4539 Beach Blvd. Telephane FL 9-2191

ORLANDO

1511 Sligh Blvd. Telephone GA 5-3537

Only Fleischmann's offers these four benefits in a "special" margarine

- 1. Exceptionally high polyunsaturated to saturated fat ratio well within the American Medical Association's definition of a "special" margarine.*
- 2. Extraordinarily delicious taste . . . so outstanding it's made Fleischmann's the country's largest selling corn oil margarines.
- **3.** Lightly Salted and Unsalted . . . yes, Fleischmann's Margarine comes Lightly Salted and Unsalted. And both Fleischmann's Margarines are made from 100% golden corn oil . . . over one half of which is liquid corn oil.
- **4.** National availability . . . unlike most competitive brands, Fleischmann's Corn Oil Margarines are in practically every grocery and supermarket throughout the country . . . at a price your patients can easily afford.

Because only Fleischmann's Margarines offer all four benefits in a "special" margarine, they're the most practical choice for your high cholesterol and low-sodium patients. Fleischmann's combines the delicious flavor your patients and their families will love with the highest polyunsaturates to saturates ratio of the nation's leading margarines. Fleischmann's taste advantage makes it much easier to keep patients on a therapeutic diet.

Fleischmann's polyunsaturated to saturated fat ratio is 1.7 to 1 (27.5% cis, cis linoleic acid), this is higher than many so-called "corn oil" margarines which are a mixture of hardened cottonseed and soybean oils with corn oil. However, the only oil used in Fleischmann's is 100% corn oil. Half of Fleischmann's corn oil is in liquid form for high linoleic content...the balance is partially hydrogenated for flavor and spreadability.

In line with A.M.A. Report—Using Fleischmann's Lightly Salted Margarine instead of butter or regular margarines increases your patients' intake of polyunsaturates...while lowering their intake of saturated fat. This is in line with the A.M.A. Report on Dietary Fat Regulation in managing atherosclerosis.*



Fleischmann's Lightly Salted Margarine—So when you recommend a regulated fat diet . . . remember Fleischmann's Lightly Salted Margarine . . . the ideal "special" margarine. It's high in polyunsaturates . . . lowest in saturated fat of the nation's leading margarines.



Fleischmann's Unsalted Margarine—Also made from 100% corn oil, Fleischmann's Unsalted Margarine is dietetically sodium-free—ideal for the patient who needs sodium restriction. It has the same high P/S

value as Fleischmann's Lightly Salted Margarine. And because it contains no salt—or preservative of any kind—Fleischmann's Unsalted Margarine is kept in the grocer's frozen food section.

*Council on Foods and Nutrition of the American Medical Association. J.A.M.A., 179, 719, 1962. J.A.M.A., 181, 139, 1962.

BALLAST POINT MANOR

SANITARIUM

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated



5226 Nichols St. Telephone 831-4191

DON SAVAGE Owner and Manager

Aged adjudged cases will be accepted on either permanent or temporary basis.

Safety against fire — by Automatic Fire Sprinkling System.

Cyclone fence enclosure for recreation facilities, seventy-five by eighty-five feet.

Member of American Medical Assn. American Hospital Assn. Florida Hospital Assn.

> P. O. Box 13467 Tampa 11, Florida

NEW Design ... Appearance ... Versatility



Burdick EK-III Dual-Speed Electrocardiograph

The all-new Dual-Speed EK-III sets a new standard in high fidelity electrocardiography for recording the fine details of rapid small deflections. With its sensitive recording system the dual-speed paper drive with 50 mm. per second speed to enlarge the horizontal dimensions of heart complexes becomes highly important. Switch from standard 25 mm. to 50 mm. and back again with no transitional lag.

Special Features:

Simplified top-loading paper drive, single 4-position Amplifier/Record switch, convenient ground indicator, all-new single-tube stylus, jacks for cardioscope and D.C. Input connections, rapid lead selection, standard 50 mm. records, modern, clean design. Without sacrificing quality or utility, the EK-III unit is compact and weighs only 22½ pounds. Call or write us for full details; and if you wish we will be glad to demonstrate the EK-III in your office.

Anderson Surgical Supply Co.

ESTABLISHED 1916

Phone CHerry 1-9589 1616 N. Orange Ave. Orlando Phone 896-3107 556 9th St. S. St. Petersburg Phone 229-8504 Morgan at Platt Tampa Phone 376-8253 729 S.W. 4th Ave. Gainesville





Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours - and provides these other advantages:

- 1. Especially suitable for maintenance therapy. Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.
- 2. Simpler dosage schedule. Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets - and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: 'Meprospan'-400 (meprobamate, sustained release) contains meprobamate 400 mg. 'Meprospan'-200 (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. Usual dosage: One 400 mg. capsule or two 200 mg, capsules at breakfast; repeat with evening meal.

Meprospan-400 meprobamate 400 mg.

sustained release

WALLACE LABORATORIES / Cranbury, N.J.



it's a long walk from gate 6...

It's a long walk from almost *anywhere* for anyone suffering the excruciating, itching discomfort of *pruritus vulvae*. ARISTOCORT Triamcinolone Acetonide Cream is highly active against the embarrassing and intolerable irritation of pruritus ani and vulvae. Sparing application to the affected area—3 to 4 times daily—usually provides rapid relief. And when excoriation of the area has led to infection, the choice of NEO-ARISTOCORT Neomycin Sulfate-Triamcinolone Acetonide will assure activity against a wide range of skin pathogens. A possible side effect may be local skin sensitization due to neomycin. Contraindications (both forms): tuberculosis of the skin, herpes simplex, and chicken pox. Prescribe tubes of 5 or 15 Gm. Also available in ½ lb. jars.

Aristocort TOPICAL CREAM 0.1% AND OINTMENT 0.1% Triamcinolone Acetonide

Aristocort CREAM 0.1% AND Neomycin Sulfate (0.5%) - Triamcinologe Acetonide (0.1%)

HCV CREME

3% Iodochlorhydroxyquin

1% Hydrocortisone

Provides ANTIFUNGAL, ANTIBACTE-RIAL, ANTI-INFLAMMATORY AND AN-TIPRURITIC action in dermatitis.

GEVIZOL

Each 5 cc. tspfl or tablet provides 100 mg. Pentylenetetrazol, 50 mg. Nicotinic acid. GEVIZOL is indicated in the treatment of the mentally confused, emotionally unstable, apathetic aged and aging patient. For the patient complaining of dizziness or fogginess. Reactivates the inactivated.

QUALITY SARON ECONOMY
PHARMACAL
CORPORATION

St. Petersburg

Florida

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Avenue, N. E. St. Petersburg, Florida Phone 862-6903



314B John Ringling Blvd Sarasota, Florida Phone 388-1604

> Box 514 Miami 62, Florida Phone 945-4055

Affiliates of Black & Skaggs Associates Battle Creek, Michigan

Proctologic Aid

PROCTO-REST is a simple device that provides a full measure of convenience in sigmoidoscopy procedures. It is designed to establish and maintain correct positioning of the patient. Its sturdy construction and formed padding provide comfort and induce relaxation.

Takes only seconds to unfold. Has locking bracket for complete safety. Can be used on any examining table.



Folds compactly for storage. Fits into the base of the examining table or a storage cupboard. Supplied in gray, white or brown upholstery.





SUPPLY COMPANY Telephone: ELgin 5-8391

1050 West Adams Street Jacksonville 3, Florida

there is nothing 'new' about Thorazine®



chlorpromazine

In the nine years since it became available to American physicians, Thorazine (chlor-promazine, SK&F) has been more widely used, more thoroughly investigated and more extensively documented than any other agent of its type.

Its actions, effects—and side effects—are well known throughout the medical profession. Its efficacy has been clearly demonstrated. And when properly used, its advantages far outweigh any possible disadvantages.

This is why there is nothing "new" about Thorazine (chlorpromazine, SK&F). This is why it remains the first choice in many conditions—and the standard against which other agents are inevitably compared.

This is why it is one of the fundamental drugs in medicine.

SMITH KLINE & FRENCH LABORATORIES, PHILADELPHIA



Look into her eyes... She needs iron, too

PANTRINSIC-C

Iron with Cobalt, Vitamin C and Hesperidin

NON-CONSTIPATING • NO G.I. UPSET • NO DIARRHEA Ideally suited for pregnant patients

Each Two PANTRINSIC-C, round, pink tablets S.C. contain:

Ferrous Fumarate	300 mg.
Hesperidin	250 mg.
Ascorbic Acid	250 mg.
Cobalt Chloride	.10 mg.
Stomach Substance	100 mg.
Whole Liver	200 mg.
Thiamine HCI	5 mg.
Vitamin B-12	.5 mcg.

Indications: For iron deficiency and anemias associated with blood loss. • Malnutrition. • Pregnancy, etc.

Dose: Just two tablets daily. Available: In bottles of 100 and 500 tablets.



Write for samples and literature...
THE BROWN PHARMACEUTICAL COMPANY

2500 West Sixth Street, Los Angeles 57, California





Out-Patient Clinic and Offices

James A. Becton, M.D.

James Keen Ward, M.D.

P. O. Box 2896, Woodlawn Station, Birmingham 6, Ala. Phone WO 1-1151 and WO 1-1152

When you put patients on "special" fat diets...

you can assure them that no corn oil margarine is higher in polyunsaturates or lower in saturates than Mrs. Filbert's Corn Oil Margarine.

And once they've tried it, they can tell you that no margarine can match Mrs. Filbert's flavor.

Mrs. Filbert's Corn Oil Margarine is a special margarine* made from 100% corn oil, over 50% of which retains its liquid characteristics.

Of the total fatty acid content 28% is cis-cis linoleic acid. Ratio of polyunsaturates to saturates is about 1.7 to 1.

For additional information, including detailed listings of component characteristics, please write to us: J.H. Filbert, Inc., Baltimore 29, Maryland.



* AMA Council on Foods and Nutrition: The Reg-ulation of Dietary Fat, JAMA 181:411-423 (Aug-ust 4, 1962). AMA Council on Foods and Nutrition: Compo-sition of Certain Margarines, JAMA 179:719 (March 3, 1962).

Specialized Service

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

E0:45

MENDICAL PROPERTY COMPANY

BOWN WATER TODONIA

Professional Protection Exclusively since 1899

MIAMI OFFICE: H. Mourice McHenry, Rep. 149 Northwest 106th Street, Miomi Shores Tel. Plaza 4-2703

APPALACHIAN HALL

ASHEVILLE

Established 1916

NORTH CAROLINA



An Institution for the diagnosis and treatment of Psychiatric and Neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin Coma, Electroshock and Psychotherapy are employed. The Institution is equipped with complete laboratory facilities including electroencephalography and X-ray.

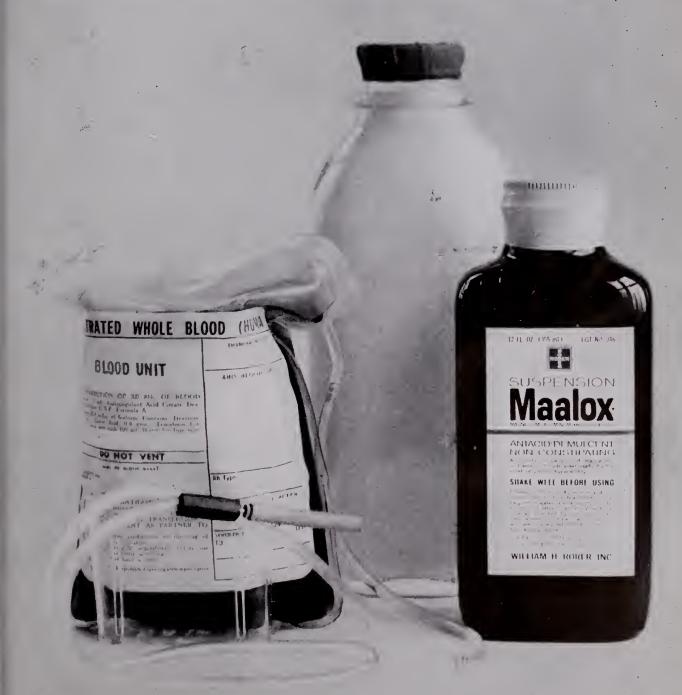
Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

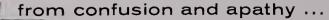
Wm. Ray Griffin Jr., M.D. Robert A. Griffin, M.D. Mark A. Griffin Sr., M.D. Mark A. Griffin Jr., M.D.

For rates and further information write Appalachian Hall, Asheville, N. C.

blood, mik and Maalox (magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy must continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation - three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)





... to Clarity and Interest

Cerebro-Nicin**

CAPSULES

A safe effective cerebral stimulant and vasodilator for your forgetful aging patient. On Cerebro-Nicin therapy, your patient shows improvement in social activity and relationships, and greater concern with personal appearance.

FORMULA:

PTZ (Pentamethylene

Tetrazole)
Nicotinic Acid100 mg
Niacinamide 5 mg
Vitamin C
Thiamine HCl 25 mg
Riboflavin 2 mg
Pyridoxine 3 mg
1-Glutamic Acid 50 mg
INDICATIONS: Apathy, dizzy spell:

INDICATIONS: Apathy, dizzy spells, mild behavior disorders, mental confusion, functional memory defects.

AVERAGE DOSE: One capsule three times daily.

AVAILABLE: Bottles of 100 and 500 capsules.

CAUTION: Most persons experience a flushing and tingling sensation after taking a higher potency niacincontaining compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause for discontinuance of the drug if the patient is forewarned to expect the reaction.

WARNING: Contraindicated in the presence of epilepsy.



Write for samples and literature...

THE BROWN PHARMACEUTICAL COMPANY
2500 West Sixth Street, Los Angeles 57, California

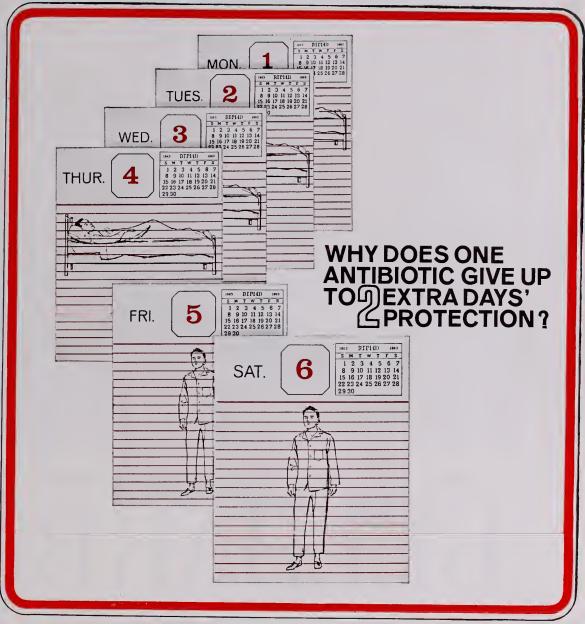
TUCKER HOSPITAL, INC.

212 West Franklin Street RICHMOND, VIRGINIA

A private hospital for diagnosis and treatment of psychiatric and neurological patients. Hospital and out-patient services.

(Organic diseases of the nervous system, psychoneuroses, psychosomatic disorders, mood disturbances, social adjustment problems, involutional reactions and selective psychotic and alcoholic problems.)

Dr. James Asa Shield Dr. George S. Fultz, Jr. DR. WEIR M. TUCKER DR. W. FREDERICK YOUNG



Because it is more resistant to disintegration, has a lower renal clearance rate than earlier tetracyclines¹...a favorable depot effect resulting from protein binding and greater mg. potency...all giving higher, sustained *in vivo* activity which continues long after the last dose.

DEMETHYLCHLORTETRACYCLINE HCI

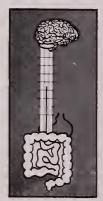
Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. Side Effects typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCl. Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d. 1. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Young Men. J. Clin. Invest. 38:1950 (Nov.) 1959.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



"The G-I tract is the barometer of the mind"



is the barometer of the mind"

Each scored white tablet contains: 1/4 gr. Phenobarbital; 0.0072 mg. Hyoscine Hydrobromide; 0.024 mg. Atropine Sulfate; and 0.128 mg. Hyoscyamine Hydrobromide. BELBARB NO. 2-Same as Belbarb but with ½ gr. Phenobarbital. BELBARB ELIXIR-Each 5 ml. is equivalent to one Belbarb tablet.

Belbarb soothes the agitated mind and calms G-I spasm through the central effect of phenobarbital and the synergistic action of belladonna alkaloids on the G-I tract.

Indications: Belbarb is of particular value in conditions associated with visceral smooth muscle spasm and tension states, such as anxiety reactions, nervous tension, visceral spasm, irritable bowel syndrome, urinary tract spasm, peptic ulcer and hypertension.

Dose: TABLETS: 1 tablet q.i.d. ½ hour before meals and at bedtime, or as directed by physician. ELIXIR: Adults: 1 teaspoon q.i.d. Children 3-12 years: ¼ to 1 teaspoon q.i.d.

Warning: May be habit forming. Caution: Do not use in patients with glaucoma or in elderly patients with prostatic hypertrophy.

Send for samples and literature.



CHARLES C. HASKELL & COMPANY, Richmond, Virginia

Division of ARNAR-STONE LABORATORIES, INC.



The FIRST Hematinic to Contain BOTH CHELATED IRON and CHE-LATED MINERALS Assuring a Truly Flavorful, Better Tolerated Iron Therapy.

ADVANTAGES -

Chelated Iron PLUS 4 Chelated Minerals
• High Therapeutic Effectiveness • Less
Irritation — even on empty stomach •
No Tooth Stain • Less Toxic • B-Vitamins
for Added Hemopoietic Activity • Pleasant Flavor • Economical

KELATRATE LIQUID HEMATINIC CHELATED IRON-MINERALS and VITAMINS

exceptionally pleasant tosting bas

Comprehensive literature and samples on request.



Westbrook Psychiatric Hospital, Inc.

(formerly Westbrook Sanatorium, Inc.)
FOUNDED 1911

Richmond, Virginia

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

REX BLANKINSHIP, M.D. President

THOMAS F. COATES, JR., M.D. Assistant Medical Director

JOHN R. SAUNDERS, M.D. Medical Director

J. McDERMOTT BARNES, M.D.
Associate

R. H. CRYTZER Administrator

BROCHURE OF LITERATURE AND VIEWS SENT ON REQUEST write to:

WESTBROOK PSYCHIATRIC HOSPITAL, INC. P. O. Box 1514, Richmond 27, Virginia Telephone 359-5701

J. Florida M.A./December, 1963



The insomniac



The tense, nervous patient



The heart-disease patient



The surgical patient



The girl with dermatosis



Tension headache



The woman in menopause



Anxious depression



Premenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of meprobamate

Miltown



The G.I. patient



WALLACE LABORATORIES Cranbury, N. J.

BELONGS IN EVERY PRACTICE

it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy.

Outstanding record of safety: Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it "belongs in every practice."

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress—and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: Indications: Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. Side Effects: Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. Complete product information available to physicians on request.

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d. SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.



For comprehensive control of the whole pain complex... helps the whole patient

Like a triad, the action of Trancogesic is direct and simple as 1,2,3. Its tranquilaxant component — chlor-mezanone — 1. reduces emotional reaction to pain . . . 2. decreases skeletal muscle spasm . . . and 3. its aspirin component dims the patient's perception of pain. Thus, Trancogesic controls the whole pain complex, helps the whole patient — with unsurpassed tolerance.

Each tablet of Trancogesic contains 100 mg. of chlormezanone and 300 mg. (5 grains) of aspirin. The usual adult dosage is 2 tablets of Trancogesic three or four times daily; the dosage suggested for children from 5 to 12 years is 1 tablet three or four times daily. Reactions to Trancogesic have been minor — gastric distress, and an occasional weakness, sedation or dizziness. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. Trancogesic is contraindicated in persons known or suspected to have an idiosyncrasy to acetylsalicylic acid. WINTHROP LABORATORIES, NEW YORK 18, N. Y.

TRANCOGESIC* CHLORMEZANONE with ASPIRIN

Winthrop

TRADEMARK

100 MG.

300 MG.

-177616

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
lorida Medical Association	Warren W. Quillian, Coral Gables	Floyd K. Hurt, Jacksonville	Hollywood, May 6-10, '64
cademy of General Practice	A. Mackenzie Manson, Jack'ville Jack R. Rudolph, Miami Francis M. Coy, Orlando Dwight J. Wharton, Jack'ville Stuart C. Smith, Tallahassee Ray. E. Kaufman, Lake Worth Miles J. Bielek, Ft. Lauderdale Sam W. Denham, Jacksonville J. Brown Farrior, Tampa Lyle W. Russell, Miami W. Ansell Derrick, Orlando John H. Cordes Jr., St. Petersburg Pedro Arroyo, Miami Leo H. Wilson Jr., Sarasota John R. Butter, St. Petersburg Merton L. Ekwall, Jacksonville Ivan Isaacs, Jacksonville L. Washington Dowlen, Miami Elwin G. Neal, Miami Shores Charles Larsen Jr., Lakeland	W. C. Fleming, Coral Gables John M. Hamilton, St. Petersburg John J. Cheleden, Daytona Beach William C. Ruffin Jr., Gainesville David Kirsh, Miami Harry W. Reinstine Jr., Jack'ville Fred H. Albee Jr., Daytona Bch. John H. Terry, Jacksonville	(Specialty Group meetings are scheduled at the time of the annual meeting of the Association)
LORIDA lasic Science Exam. Board lood Banks, Association lue Cross of Florida, Inc. lue Shield of Florida, Inc. lancer Council. liabetes Association lental Society, State. leart Association lospital Association loard of Medical Examiners lurses Association	P. A. Vestal, Winter Park Fred J. Woods, Tampa Mr. C. DeWitt Miller, Orlando W. Dean Steward, Orlando George F. Schmitt, Miami Richard C. Chace, Orlando Henry R. Cooper, Ft. Lauderdale Middleton T. Mustian, Gainesville Courtlandt D. Berry, Orlando Marion E. McKenna, Daytona Bch.		Gainesville, June 6, '64 Ft. Lauderdale, Apr. 24-26, '64 November, 1964 Hollywood, May 6-10, '64 Miami Beach, Oct., '64 Miami Beach, May 24-27, '64 Miami Beach, May 25-26, '64 November, 1964 Miami Beach, June 28-30, '64
'harmaceutical Assn., State ublic Health, Association horacic Society 'uberculosis & Health Assn √oman's Auxiliary merican Medical Association	Walter D. Griffin Jr., Jax	Mr. R. Q. Richards, Ft. Meyers Mr. Everett H. Williams Jr., Jax. David M. Travis, Gainesville R. A. Caruthers, Orlando Mrs. Richard Reeser Jr., St. P'burg F. J. L. Blasingame, M.D., Chicago	San Francisco, June 21-25, '64
A.M.A. Clinical Session			Portland, Ore., Dec. 1-4, '64

BRAWNER HOSPITAL, INC.

(Established 1910)

2932 South Atlanta Road, Smyrna, Georgia

FOR THE TREATMENT OF PSYCHIATRIC ILLNESSES AND PROBLEMS OF ADDICTION

MODERN FACILITIES

JAS. N. BRAWNER, JR., M.D.

Medical Director

ALOYSIUS I. MILLER, M.D. MARK A. GOULD, M.D.

Phone HEmlock 5-4486

County Medical Societies of Florida

					000000000000000000000000000000000000000
SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	Associat	Associate Active
Alachua	Billy Brashear, Gainesville	Carl E. Van Arnam, Gainesville	2nd Tues.	15	121
*Bradford, Guchrist, Union Bay Brevard Broward Charlotte Clay Collier	A. Ralph Monaco, Panama City Albert F. Stratton Jr., Cocoa Gordon B. Carver, Fort Lauderdale Stephen R. Roddy, Punta Gorda Hinson L. Stephens, Orange Park John C. Garland, Naples	Owen Reese Jr., Panama City Adrian R. Jensen, Rockledge Yale Citrin, Hollywood Arno von Ruckteschell, Punta Gorda Aubrey Y. Covington, Green Cove Spgs. Ethel H. Trygstad, Naples Barney E. McRae Jr., Lake City	1st Tues. 1st Tues. 4th Tues. 2nd Tues. 4th Tues. 3rd Wed.	65 65 0 0 1	33 111 329 10 7 17
*Baker Dade DeSoto-Hardee-Glades Duval Escambia Franklin-Gulf Gadsden-Liberty Highlands Hillsborough Indian River Jackson-Calhoun	Julius Alexander, Miami James R. Whitehurst, Bowling Green Hugh A. Carithers, Jacksonville Gerald H. Hilbert, Pensacola Photis J. Nichols, Apalachicola J. Lloyd Massey, Quincy Burton C. Ostling, Avon Park Marshall E. Smith, Tampa Donald D. Gold, Vero Beach Jabe A. Breland, Marianna H. Durham Young Jr., Leesburg	Richard C. Clay, Miami Malcolm M. Sayre, Wauchula Richard T. Shaar, Jacksonville Leonard F. Hattaway, Pensacola William F. Wager, Port St. Joe Thomas M. Daniel, Avon Park Frank A. Massari, Tampa E. B. Hardee Jr., Vero Beach Francis M. Watson, Marianna Argin A. Boggus Jr., Tavares Roy S. Giles, Rort Myers	lst Tues. 1st Tues. 1st Tues. 2nd Tues. Last Wed. Quarterly 3rd Mon. 1st Tues. 2nd Tues. 2nd Tues. Quarterly 3rd Mon.	161 0 45 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1,211 358 126 126 17 17 19 19 17 13
Leon Wakulla-Jefferson Madison Manatee Marion	David J. McCulloch, Tolt Myels David J. McCulloch, Tallahassee Thomas G. Bouland Jr., Madison Joseph B. Ganey, Bradenton Margaret Palmer, Ocala	James K. Con, Tallahasse Royce V. Jackson, Madison Haskell H. Bass Jr., Bradenton David C. Albritton, Ocala		34 17	75 50 36
Monroe Nassau Orange *Oscoola	Philip R. Dobert, Key West Benjamin F. Dickens, Fernandina Bch. Charles R. Sias, Orlando	Elmer J. Eisenbarth, Key West Daniel M. Jacobs Jr., Fernandina Bch. Truett H. Frazier, Orlando	1st Thurs	2 53	23 9 269
Palm Beach Pasco-Hernando-Citrus	Samuel A. Manalan, W. Palm Beach Dwayne L. Deal, Dade City	Nicholas S. Petkas, West Palm Beach W. Wardlaw Jones, Dade City	4th Mon. 2nd Thurs.	20	238 22
Pinellas Polk Putnam St. Johns St. Lucie-Okeechobee-Martin Sarasota Seminole Suwannee-Hamilton-Lafayette Taylor	Robert A. Biles, St. Petersburg Paul E. Coury, Lakeland Charles E. Barrineau, Palatka James J. DeVito, St. Augustine Melvin Wokowsky, Fort Pierce Douglas R. Murphy, Venice Edwin L. Lindsey, Sanford Charles R. Wiley, Perry	A. Y. Wilcox Jr., St. Petersburg Albert G. King Jr., Lakeland James R. Sayers, Palatka William W. O'Connell, St. Augustine George Theodrou, Fort Pierce Rudolph C. Garber Jr., Sarasota John T. Johnson, Sanford James F. Dietrich, Live Oak John A. Dyal Jr., Perry	lst Mon. 2nd Wed. 2nd Tues. 3rd Tues. 3rd Thurs. 2nd Tues. 2nd Tues. 1st Sat. Last Fri.	45 14 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	358 159 14 20 20 20 20 5
Volusia ***Elization	Carroll M. Crouch, Daytona Beach	Michael R. Blais, Daytona Beach	2nd Tues.	2	111
Walton-Okaloosa-Santa Rosa Washington-Holmes	-Hiram M. Melvin, Milton Ralph H. Segrest, Bonifay	Elbert W. Sutton, Milton Jimmy F. Henry, Chipley	3rd TuesQuarterly	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	44 5 4 436

FLORIDA MEDICAL ASSOCIATION OFFICERS, COUNCILS AND COMMITTEES

OFFICERS	COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS
WARREN W. QUILLIAN, M.D., President	THOMAS C. KENASTON SR., M.D., Chm
SAMUEL M. DAY, M.D.,	DENTISTRY
President-ElectJacksonville	
H. PHILLIP HAMPTON, M.D., Vice President	JOSEPH E. O'MALLEY, M.D., ChmC-67 Orlando DIRAN M. SEROPIAN, M.D., AL-64 Fort Lauderdale BERNARD L. N. MORGAN, M.D., A-64 Jacksonville
FUGENE G PEEK IR M D	LEO H. WILSON JR., M.D. B-66 Sarasota JAMES G. ROBERTSON, M.D. D-65 Miami
Speaker of the House	LAW
FRANKLIN J. EVANS, M.D., Vice Speaker	PEN I CHERDARD M.D. Cha. D.C.
FLOYD K. HURT, M.D., Secretary-Treasurer	BEN J. SHEPPARD, M.D., Chm. D-67 Coral Gables LAWRENCE V. HASTINGS, M.D. AL-64 Miami
DODEDT E ZELLNED M.D.	RANEY A. OVEN, M.D. A-66 Tallahassee JAMES R. BOULWARE JR., M.D. B-65 Lakeland CARROLL M. CROUCH, M.D. C-64 Daytona Beach
Immediate Past PresidentOrlando	
EXECUTIVE DIRECTOR	MEDICAL ASSISTANTS
W. HAROLD PARHAMJacksonville	ENSOR R. DUNSFORD JR., M.D., Chm. A-67 Jacksonville FRANCIS T. HOLLAND, M.D. AL-64 Tallahassee
BOARD OF GOVERNORS	FRANCIS C. HOARE, M.D. B-66 Clearwater CHARLES R. SIAS, M.D. C-65 Orlando JAMES L. ANDERSON, M.D. D-64 Miami
WARREN W. QUILLIAN, M.D.,*	
Chm., Ex Officio	MEDICAL TECHNOLOGISTS
(President-Elect) Ex OfficioJacksonville	MILLARD B. WHITE, M.D., Chm. B-67 Sarasota WILLIAM G. ECKERT, M.D. AL-64 Tampa
H. PHILLIP HAMPTON, M.D., (Vice President) Ex Officio	WILLIAM G. ECKERT, M.D. AL-64 Tampa SANFORD A. MULLEN, M.D. A-66 Jacksonville JACKSON L. THATCHER, M.D. C-65 West Palm Beach
EUGENE G. PEEK JR., M.D., (Speaker of the House) Ex OfficioOcala	JOIIN B. MIALE, M.D. D-64Miami
FLOYD K, HURT, M.D.,*	NURSING
(Secretary-Treasurer) Ex OfficioJacksonville ROBERT E. ZELLNER, M.D.*PP-65Orlando	THOMAS C. KENASTON SR., M.D., Chm. C-67
S. CARNES HARVARD, M.D.*PP-64Brooksville JACK Q. CLEVELAND, M.DAL-64Coral Gables	THOMAS C. KENASTON SR., M.D., Chm. C-67 Cocoa WILLARD H. H. BENNETT, M.D. Al-64 Titusville WALTER C. PAYNE JR., M.D. A-64 Pensacola COUNCILL C. RUDOLPH, M.D. B-65 St. Petershurg
HENRY J. BABERS JR., M.D A-66 Gainesville	JAMES J. HUTSON, M.D. D-66
EDWARD L. COLE JR., M.D B-67. St. Petersburg CHAS, J. COLLINS, M.D C-65 Orlando	PHARMACY
RALPH S. SAPPENFIELD, M.DD-64Miami	JESSE W. CASTLEBERRY, M.D., Chm. C.67 Orlando
REUBEN B. CHRISMAN JR., M.DAMA Delegate-64Coral Gables	BEN C. STOREY, M.D. AI-64 Titusville GRETCHEN V. SQUIRES, M.D. A-64 Pensacola JOSEPH A. EZZO, M.D. B-65 St. Petersburg M. JAY FLIPSE, M.D. D-66 Miami
LEO M. WACHTEL, M.DSBH-64Jacksonville *Executive Committee	M. JAY FLIPSE, M.D. D-66 Miami
†Public Relations Officer	PHYSICAL THERAPY
Subcommittees: Florida Medical Foundation	KENNETH PHILLIPS, M.D., ChmD-67 Coral Gables
EDWARD JELKS, M.D	DANIEL KINDLER, M.D., AL-64 Miami JOSEPH C, SHIPP, M.D., A-64 Gaine sville
Inter-American Relations JOHN T. KILPATRICK, M.D., Chm. Miami	JOSEPH C. SHIPP, M.D.A-64GainesvilleHUBERT W. COLEMAN, M.D.B-65Avon ParkLOUIS J. NOVAK, M.D.C-66Hollywood
JOHN T. KILPATRICK, M.D., Chm. Miami FRANKLIN J. EVANS, M.D. Coral Gables RALPH S. SAPPENFIELD, M.D. Miami RICHARD F. STOVER, M.D. Miami	PODIATRY
WILLIAM B. WELCH, M.DMiami	WALLACE E. MILLER, M.D., Chm. D-67 Miami IESTER A. RUSSIN, M.D. Al-64 Miami Beach
Medicine and Religion CURTIS D. BENTON IR., M.D.,	WILLIAM J. HUTCHISON, M.DA-65
Chm. C Fort Lauderdale EDWARD J. LAUTH JR., M.D., AL Miami	ALBERT A. WILSON, M.D. B-66 Tampa LOUIS P. BRADY, M.D. C-64 Orlando
Chm. C. Fort Lauderdale EDWARD J. LAUTH JR., M.D., AL Miami GRETCHEN V. SQUIRES, M.D. A Pensacola SIDNEY GRAU, M.D. B St. Petersburg	VETERINARY MEDICINE
CORREN P. YOUMANS, M.D. D. Miami Quackery	CLIFFORD C. SNYDER, M.D., ChmD-67 Coral Gables
EDWARD L. COLE JR., M.D., Chm. St. Petersburg	JOSEPH L. G. LESTER JR., M.D. AL-64
JULIUS ALEXANDER, M.D. Miami IRVING E. HALL JR., M.D. Bradenton WILLIAM C. ROBERTS, M.D. Panama City	SIDNEY SMITH, M.D. B-65 Bradenton HENRY W. SHUPE, M.D. C-64 Clewiston
	X-RAY TECHNICIANS
Venomous Snake Bite NEWTON C. McCOLLOUGH,	
M.D., Chm. C-65 Orlando CARL E. ANDREWS, M.D. AL-64 West Palm Beach RAY O. EDWARDS IR., M.D. A-67 Jacksonville VENDETTH W. LACKEON M.D. P. 64 Leks Alfred	RAYMOND E. PARKS, M.D., Chm D-67 Miami GEORGE J. MEYER, M.D. AL-64 Fort Lauderdale ANDREW F. GIESEN JR., M.D. A-65 Fort Walton Beach
KENNETH W. JACKSON, M.D. B-64 Lake Alfred JOHN E. DEES, M.D. D-66 Miami	ROBERT F. CONTI, M.D. B-64 Fort Myers HERBERT D. KERMAN, M.D. C-66 Daytona Beach
JOINT DI DODO, 1.11Di	

HIDICIAL COUNCIL

JUDICIAL COUNCIL	NATIONAL LEGISLATION
JERE W. ANNIS, M.D., Chm. Lakeland	H. PHILLIP HAMPTON, M.D., Chm. Tampa
	Subcommittee Liaison with Federal Agencies ROY E. CAMPBELL, M.D., Chm. Palatka BURNS A. DOBBINS JR., M.D., Department of Defense Fort Lauderdale JERE W. ANNIS, M.D., Department of Health, Education and Welfare Lakeland ROBERT H. MICKLER, M.D., Dept. of Justice Tallahassee THOMAS I. BIXJER M.D., Dept. of Labor Tallahassee
ARCHIVES	BURNS A. DOBBINS JR., M.D.,
CLIFFORD C. SNYDER, M.D., Chm. D-66 Coral Gables WILLIAM M. STRAIGHT, M.D. AL-64 Miami	Department of DefenseFort Lauderdale JERE W. ANNIS, M.D., Department of
WILLIAM M. STRAIGHT, M.D. AL-64 Miami GEORGE W. MORSE, M.D. A-67 Pensacola W. WARDLAW JONES, M.D. B-65 Dade City HUGII WEST, M.D. C-64 DeLand	Health, Education and Welfare Lakeland ROBERT H. MICKLER, M.D., Dept. of Justice Tallahassee
HUGII WEST, M.D. C-64 DeLand	THOMAS J. BIXLER, M.D., Dept. of Labor Tallahassee
GRIEVANCE	ROY E. CAMPBELL, M.D., Department of Veterans Administration Palatka
JERE W. ANNIS, M.D., Chm. Lakelaud RALPH W. JACK, M.D. Miami LEO M. WACHTEL, M.D. Jacksonville S. CARNES HARVARD, M.D. Brooksville ROBERT E. ZELLNER, M.D. Orlando	COUNCIL ON MEDICAL ECONOMICS
S. CARNES HARVARD, M.D. Brooksville	BURNS A. DOBBINS JR., M.DChm. Fort Lauderdale
ROBERT E. ZELLNER, M.DOrianao	De 121.5 II. De Dilitto Jili, Mid-imiento il Laureriuse
MEDICAL LICENSURE	ADVISORY TO BLUE SHIELD
HOMER L. PEARSON JR., M.D., Chm. Miawi ALPHEUS T. KENNEDY, M.D. Pensacola JOSEPH S. STEWART, M.D. AL-64 Miami	JACK A. MaCRIS, M.D., Chm. B-66 St. Petersburg IAMFS D. BEFSON, M.D. AL-64 Jacksonville J. WAYNE HENDRIX, M.D. A-64 Port St. Jacksonville C. MERRILL WHORTON, M.D. A-67 Jacksonville EARL G. WOLF, M.D. A-65 Pensacola RAYMOND J. FITZPATRICK, M.D. A-66 Gainesville IRVING M. ESSRIG, M.D. B-64 Tampa THOMAS W. DORR, M.D.—B-65 Tampa HENRY G. MORTON, M.D. B-67 Sarasota CHARLES R. SIAS, M.D. C-64 Orlando CARL S. McLEMORE, M.D. C-65 Orlando HOHN R. MAHONEY, M.D. C-66 Fort Lauderdale MYRL SPIVEY, M.D. C-67 West Palm Beach
JOSEPH S. STEWART, M.D. AL-64 Miami	C. MERRILL WHORTON, M.D. A-67 Jacksonville
MEMBERSHIP AND DISCIPLINE	RAYMOND J. FITZPATRICK, M.D. A-66 Gainesville
District I—SIDNEY G. KENNEDY JR., M.D66Pensacola	THOMAS W. DORR, M.D.—B-65 Tampa
WILLIAM C. ROBERTS, M.D. 67 Panama City District 2—ASHBEL C. WILLIAMS, M.D. 66 Jacksonville	HENRY G. MORTON, M.D. B-67 Sarasota CHARLES R. SIAS, M.D. C-64 Orlando
RAYMOND H. KING, M.D. 67 Jacksonville District 3—EDWARD J. LAUTH JR., M.D. 64 Miami	CARL S. McLEMORE, M.D. C-65 Orlando IOHN R. MAHONEY, M.D. C-66 Fort Landerdale
JOHN R. HILSENBECK, M.D. 66 Miami District 4—FRAZIER J. PAYTON, M.D. 65 Miami	MYRL SPIVEY, M.D. C-67 West Palm Beach FRANK G. WILSON, M.D. D-64 Miami GEORGE S. BALDRY, M.D. D-65 Miami
NELSON ZIVITZ, M.D., 64 Miami Beach District 5—W. WARDLAW JONES, M.D., 64 Dade City	GEORGE S. BALDRY, M.D. D-65 Miami
District I—SIDNEY G. KENNEDY JR., M.D 66 Pensacola WILLIAM C. ROBERTS, M.D 67 Panama City District 2—ASHBEL C. WILLIAMS, M.D 66 Jacksonville RAYMOND H. KING, M.D. 67 Jacksonville District 3—EDWARD J. LAUTH JR., M.D. 64 Miami IOHN R. HILSENBECK, M.D 66 Miami District 4—FRAZIER J. PAYTON, M.D. 65 Miami NELSON ZIVITZ, M.D. 64 Miami Beach District 5—W. WARDLAW JONES, M.D 64 Dade City JOHN J. CHELFDEN, M.D 66 Daytona Beach District 6—WILLIAM H. PROCTOR,	WILEY M. SAMS, M.D. D-66 Miami JAMES L. ANDERSON, M.D. D-67 Miami
M.D. 66 West Palm Beach MILES J. BIELEK, M.D. 67 Fort Lauderdale District 7—JOHN M. BUTCHER, M.D.—66 Sarasota	COMMERCIAL HEALTH INSURANCE
GORDON H. McSWAIN,	DUNCAN T. McEWAN, M.D., Chm. AL-64 Orlando JOHN H. TERRY, M.D. A-64 Jacksonville WILLIAM H. KEELER III, M.D. B-67 St. Petersburg DAVID J. LEHMAN JR., M.D. C-66 Holtywood JACK KEEFF III, M.D. D-65 Miami
GORDON H. McSWAIN, M.D., Chm. 67 Arcadia District 8—THOMAS II. BATES, M.D. 64 Lake City	WILLIAM H. KEELER III, M.D. B-67 St. Petersburg
District 8—THOMAS II. BATES, M.D. 64 Lake City WILLIAM C. THOMAS SR., M.D. 65 Gaincsville District 9—IAMES T. COOK, M.D. 65 Marianna	JACK KEEFF III, M.D. D-65 Miami
WILLIAM C. THOMAS SR., M.D. 65 District 9—JAMES T. COOK, M.D. 65 Marianna GEORGE II. GARMANY, M.D. 67 District 10—ERNEST R. BOURKARD, M.D. 64 Tampa C. FRANK CHUNN, M.D. 65 Tampa District 11—THOMAS C. KENASTON SR., M.D. 65 FRANK C. BONE, M.D67 District 12—EDWARD L. COLE JR., M.D. 65 St. Petersburg	FEE SCHEDULES
District 10—ERNEST R. BOURKARD, M.D. 64 Tampa C. FRANK CHUNN, M.D. 65 Tampa	
District 11—THOMAS C. KENASTON SR., M.D. 65 Cocoa FRANK C. BONE, M.D. 67 Orlando	HENRY J. BABERS JR., M.D., Chm. A-66 Gainesville NEWTON C. McCOLLOUGH, M.D. AL-64 Orlando
District 12—EDWARD L. COLE JR., M.D. 65	PAUL J. McCLOSKEY, M.D. B-67 Tampa
M.D. 65 N. WORTH GABLE, M.D. 64 St. Petersburg	BURNS A. DOBBINS JR., M.D. C-64 Fort Lauderdale
COUNCIL MEMBER FROM BOARD OF PAST PRESIDENTS	NEWTON C. McCOLLOUGH, M.D. AL-64 Orlando HENRY L. HARRELL, M.D. A-65 Ocala PAUL J. McCLOSKEY, M.D. B-67 Tampa WILLIAM J. DEAN, M.D. B-66 St. Petersburg BURNS A. DOBBINS JR., M.D. C-64 Fort Lauderdale JAMES F. COONEY, M.D. C-67 West Palm Beach RALPH S. SAPPENFIELD, M.D. D-64 Miami OLIVER P. WINSLOW JR., M.D. D-65 Miami
LEO M. WACHTEL, M.D Jacksonville	MEMBERS INSURANCE
COUNCIL ON LEGISLATION AND	
PUBLIC AGENCIES	H. CLINTON DAVIS, M.D., Chm. D-66 Miami H. LAWRENCE SMITH, M.D. AL-64 Taliahassee FLOYD K. HURT, M.D. A-64 Jacksonville WILLIS W. HARRIS, M.D. B-67 Bradenton BENNETT J. LACOUR JR., M.D. C-65 Daytona Beach
H. PHILLIP HAMPTON, M.D., Chm	WILLIS W. HARRIS, M.D. B-67 Bradenton
STATE LEGISLATION	
GEORGE S. PALMER, M.D., Chm. AL-64 Tailahassee	OCCUPATIONAL HEALTH
GUGENE G. PEEK JR., M.D. A-66 Ocala JOHN F. OREBAUGH, M.D. B-67 St. Petersburg WALTER J. GLENN JR., M.D. C-65 Fort Lauderdale	NEWTON C. McCOLLOUGH, M.D., Chm. AL-64 Orlando P. G. BATSON JR., M.D. A-65 Pensacola
WALTER J. GLENN JR., M.D. C-65 Fort Lauderdale	P. G. BATSON JR., M.D. A-65 Pensacola CHARLES LARSEN JR., M.D. B-66 Lakeland LLOYD J. NETTO, M.D. C-64 West Palm Beach TRUXTON L. JACKSON, M.D. D-67 Miami
EDWARD R. ANNIS, M.D. D-64 Miami EDWARD JELKS, M.D., Advisory Jacksonville	TRUXTON L. JACKSON, M.D. D-67
Subcommittee Liaison with State Agencies The Charles Translation of the Cha	COUNCIL ON MEDICAL EDUCATION
FRANCIS T. HOLLAND, M.D., Chm. Tallahassee PAUL S. JARRETT, M.D., Alcoholic Rehabilitation Miami EUGENE G. PEEK JR., M.D., SBH Ocala GEORGE S. PALMER, M.D.,	AND HOSPITALS
GEORGE S. PALMER, M.D.,	HUGH A. CARITHERS, M.D., Chm. Jacksonville
GEORGE S. PALMÉR, M.D., Children's Commission Tallahassee MARION W. HESTER, M.D., Council for the Blind Lakeland FRANCIS T. HOLLAND, M.D., Crippled Children's Commission Tallahassee CHARLOTTE C. MAGUIRE, M.D., Division of Child Training Orlando RAYMOND J. FITZPATRICK, M.D., Division of Correction Gainesville ZACK RUSS IR., M.D., Division of Mental Health Tampa	HOSPITALS
FRANCIS T. HOLLAND, M.D., Crippled Children's Commission Tallahassee	
CHARLOTTE C. MAGUIRE, M.D., Division of Child Training Orlando	JOHN S. STEWART, M.D., Chm. B-67 Fort Myers ALBERT F. STRATTON JR., M.D. AL-64 Cocoa
RAYMOND J. FITZPATRICK, M.D., Division of Correction	ALBERT F. STRATTON JR., M.D. AL-64 Cócoa RAYMOND B. SQUIRES, M.D. A-65 Pensacola WALTER J. GLEÑN JR., M.D. C-64 Fort Lauderdole ROBERT F. DICKEY, M.D. D-66 Miami
ZACK RUSS JR., M.D., Division of Mental Health Tampa IRVING E. HALL JR., M.D., Education Dept. Bradenton THOMAS J. BIXLER, M.D.,	
THOMAS J. BIXLER, M.D., Industrial Commission Tallahassee	INTERNSHIPS AND RESIDENCIES
Industrial Commission Tallahassee JERE W. ANNIS, M.D., Public Welfare Lakeland CHARLES K. DONEGAN, M.D.,	HUGH A. CARITHERS, M.D., Chm. A-65 Jacksonville WILLIAM H. PROCTOR, M.D. AL-64 West Palm Beach
Tuberculosis Board St. Petersburg	ACHILLE A. MONACO, M.D., C-64 Daytona Beach
Vocational Rehabilitation Daytona Beach	WILLIAM M. STRAIGHT, M.D. D-67

NATIONAL LEGISLATION

MEDICAL SCHOOLS

EDWARD W. CULLIPHER, M.D., Chm. D-66	
Dade County Medical Assn.	Miami
MILTON M. COPLAN, M.D. AL-64	Miami
J. MAXEY DELL JR., M.D., A-67	
Alachua County Medical Society	
C. FRANK CHUNN, M.D. B-65	Tampa
CHAS. J. COLLINS, M.D. C-64 HAYDEN C. NICHOLSON, M.D.,	Orlando
HAYDEN C. NICHOLSON, M.D.,	
Faculty, U. of Miami	Miami
GEORGE T. HARRELL, M.D.,	
Faculty, U. of Florida	Gainesville

PHYSICIAN PLACEMENT

JAMES T. COOK, M.D., Chm. A-67	Marianna
MELVIN M. SIMMONS, M.D. AL-64	Sarasota
ARTHUR J. WALLACE, M.D., B-66	Tampa
DAVID W. GODDARD, M.D. C-65	- Daytona Beach
HOMER L. PEARSON JR., M.D D-64	Miami

COUNCIL ON MEDICAL SERVICES

CHARLES	R.	SIAS,	M.D.,	Chm.			Orlando
---------	----	-------	-------	------	--	--	---------

AGING

WILLIAM R. DANIEL, M.D., ChmAL-64		Orlando
CHARLES J. KAHN, M.D., A-66		Pensacola
JAMES A. WINSLOW JR., M.D. B-65		Tampa
LOUIS L. AMATO, M.D. C-64	Fort	Lauderdale
CARLOS P. LAMAR, M.D. D-67		Miami
Criticos 1. Erimini, militar b 0.		

BLOOD

JOSEPH C. VON THRON, M.D., Chm. C-67 Coco	a Beach
FAIRFAX E. MONTAGUE, M.D. AL-64	Palatka
GERARD H. HILBERT, M.D. A-66	
WILLIAM G. ECKERT, M.D. B-65	
O. WHITMORE BURTNER, M.D. D-64	Miami

CHILD HEALTH

1RV1NG E. HALL JR., M.D., Chm B-64	Bradenton
ADRIAN Q. POLLOCK, M.D. AL-64	Fort Myers
RICHARD G. SKINNER JR., M.D. A-65	Jacksonville
ANDREW W. TOWNES, M.D C-67 =	Orlando
WESLEY S. NOCK, M.D D-66	Coral Gables

EMERGENCY MEDICAL SERVICE

JAMES L. CAMPBELL JR., M.D., Chm.	C-64 Orlando
ALPHEUS T. KENNEDY, M.D. AL-64	Pensacola
	Jacksonville
JOHN M. BUTCHER, M.D. B-64	Sarasota
JOSEPH S. STEWART, M.D. D-64	Miami

HEARING

G. DEKLE TAYLOR, M.D., ChmA-66	Jacksonville
GEORGE T. SINGLETON, M.D. AL-64	GainesviHe
J. BROWN FARRIOR, M.D. B-65	. Tampa
JOHN H. WEBB JR., M.D., C-64	Orlando
JAMES R. CHANDLÉR, JR., M.D. D-67	Miami

INDIGENT CARE

NELSON ZIVITZ, M.D., Chm. D-65	Miami Beach
ROBERT L. TOLLE, M.DAL-64	. Orlando
EDWARD JELKS, M.DA-64	Jacksonville
BENJAMIN J. MEADOWS JR., M.D. B-67	Tampa
JOHN J. CHELEDEN, M.D. C-66	Daytona Beach

LABOR

THEODORE J. KAMINSKI, M.D., Chm C-6	
LAURENT P. Laroche, M.D. AL-64	Cocoa Beach
PAUL F. BARANCO, M.DA-64	. Pensacola
GEORGE J. SUAREZ, M.D. B-67	Tampa
EDWARD R. ANNIS, M.D. D-65	Miami
EDWARD R. ANNIS, M.D. D-65	Miami

MATERNAL HEALTH

JAMES M. INGRAM, M.D., ChmAL-64	Tampa
JOSEPH W. DOUGLAS, M.D. A-66	Pensacola
S. L. WATSON, M.D. B-64	Lakeland
JAMES R. SORY, M.D C-65	West Palm Beach
WILLIAM T. MIXSON JR., M.D. D-67	Coral Gables

MENTAL HEALTH

ZACK RUSS JR., M.D., Chm. B-65	Tampa
WILLIAM M. C. WILHOIT, M.D. AL-64	Pensacola
JOHN A. RITCHIE, M.D. A-66	Jacksonville
JAMES W. ETTINGER, M.D C-64	Rockledge
EDWARD H. WILLIAMS, M.D. D-67	Coral Gables

PUBLIC HEALTH

CHARLES R. SIAS, M.D., ChmAL-64	Orlando
SIMON D. DOFF, M.D. A-65	Jacksonville
LEFFIE M. CARLTON JR., M.D. B-67	Tampa
CLARENCE L. BRUMBACK, M.D. C-64	West Palm Beach
JOHN D. MILTON, M.DD-66	Coral Gables

RURAL HEALTH

J. BASIL HALL, M.D., Chm C-66	Tavares
DONALD C. HARTWELL, M.D. AL-64	Avon Park
GEORGE W. KARELAS, M.D. A-64	Newberry
FORREST HINTON, M.D. B-67	Immokalee
ELMER J. EISENBARTH, M.D. D-65	Orlando

VISION

CURTIS D. BENTON JR.,	F . T . T .
M.D., ChmC-65	Fort Lauderdale
MARION W. HESTER, M.DAL-64	Lakeland
THOMAS S. EDWARDS, M.DA-67	Jacksonville
JOSEPH W. TAYLOR JR., M.D. B-66	Татра
KENNETH S. WHITMER, M.D. D-64	Miami

SCIENTIFIC COUNCIL

THAD	MOSELEY.	M.D.,	Chm			Jacksonville
------	----------	-------	-----	--	--	--------------

THE JOURNAL AND OTHER PUBLICATIONS

THAD MOSELEY, M.D., Editor	Jacksonville
SHALER RICHARDSON, M.D., Editor Emeritus.	Jacksonville
FRANZ H. STEWART, M.D., Assistant Editor	Miami
CHARLES K. DONEGAN, M.D.,	
Assistant Editor	St. Petersburg
IOHN M PACKARD M D Assistant Editor	Pensacola

POSTGRADUATE EDUCATION

CHAS. J. COLLINS, M.D., Chm. C-65	Orlando
ALBERT G. KING JR., M.DAL-64	Lakeland
WILLIAM C. THOMAS JR., M.D. A-67	Gainesville
RICHARD G. CONNAR, M.D. B-66	Tampa
JOHN V. HANDWERKER JR., M.D. D-64	Miami

RESEARCH

KARL B. HANSON, M.D., Chm. A	Jacksonville
DONALD W. SMITH, M.D. AL	Miami
MILLARD B. WHITE, M.D. B	Sarasota
MARTIN G. GOULD, M.D. C	Fort Pierce
JAMES J. GRIFFITTS, M.D. D.	Miami

SCIENTIFIC WORK

RICHARD C. DEVER, M.D., Chm. D-66	Miami
RICHARD T. SMITH, M.D. AL-64	Gainesville
THAD MOSELEY, M.DA-64	Jacksonville
CHARLES H. LAŚLEY, M.D. B-67	Clearwater
OSCAR W. FREEMAN, M.D C-65	Orlando

COUNCIL ON SPECIAL ACTIVITIES

WALTER C. PAYNE SR., M.D., Chm. Pensacol	WALTER	C. PAYNE	SR.,	M.D.,	Chm.	Pensacola
--	--------	----------	------	-------	------	-----------

ADVISORY TO WOMAN'S AUXILIARY

GORDON H. IRA, M.D., ChmA-67.	Jacksonville
W. DEAN STEWARD, M.D. AL-64	Orlando
EUGENE B. MAXWELL, M.D. B-65	Tampa
LEE ROGERS JR., M.D., C-64	Rockledge
DONALD F. MARION, M.D. D-66	Miami

BOARD OF PAST PRESIDENTS

WALTER C. PAYNE SR., M.D., Chm., 194	9 _ Pensacola
ROBERT E. ZELLNER, M.D., Secv., 1962	Orlando
FREDERICK J. WAAS, M.D., 1928	Jacksonville
WILLIAM M. ROWLETT, M.D., 1933	Tampa
HOMER L. PEARSON JR., M.D., 1934	Miami
ORION O. FEASTER, M.D., 1936	Long Beach, Miss.
EDWARD JELKS, M.D., 1937	Jacksonville
WALTER C. JONES, M.D., 1941	Miami
EUGENE G. PEEK SR., M.D., 1943	Ocala
SHALER RICHARDSON, M.D., 1946	Jacksonville
WILLIAM C. THOMAS SR., M.D., 1947	. Gainesville
JOSEPH S. STEWART, M.D., 1948	Miami
HERBERT E. WHITE, M.D., 1950	St. Augustine
DAVID R. MURPHEY JR., M.D., 1951	Tampa
ROBERT B. McIVER, M.D., 1952	Jacksonville

FREDERICK K. HERPEL, M.D., 1953	West Palm Beach
DUNCAN T. McEWAN, M.D., 1954	Orla do
JOHN D. MILTON, M.D., 1955	Coral Gables
FRANCIS H. LANGLEY, M.D., 1956	St. Petersburg
WILLLIAM C. ROBERTS, M.D., 1957	Panama City
JERE W. ANNIS, M.D., 1958	Lakeland
RALPH W. JACK, M.D., 1959	
LEO M. WACHTEL, M.D., 1960	
S. CARNES HARVARD, M. D., 1961	Brooksville

A.M.A. HOUSE OF DELEGATES

REUBEN B. CHRISMAN JR., M.D.,	
	Coral Gables
	Orlando
(Terms expire Dec. 31, 1964)	
FRANCIS T. HOLLAND, M.D., Delegate	Tallahassee
MADISON R. POPE, M.D., Alternate	
(Terms expire Dec. 31, 1964)	· ·
JERE W. ANNIS, M.D., Delegate	Lakeland
LEO M. WACHTEL, M.D., Alternate	Jacksonville
(Terms expire Dec. 31, 1964)	
MEREDITH MALLORY, M.D., Delegate	Orlando
EUGENE G. PEEK JR., M.D., Alternate	Ocala
(Terms expire Dec. 31, 1963)	
BURNS A. DOBBINS JR., M.D., DelegateFord	
WALTER E. MURPHREE, M.D., Alternatc	Gainesville
(Terms expire Dec. 31, 1963)	

COUNCIL ON SPECIALTY MEDICINE

EMMET F. FERGUSON JR., M.D., Chm	Jacksonville
Committees: Anesthesiology	
JAMES D. BEESON, M.D., 1967 Dermatology	Jacksonville
JACK H. BOWEN, M.D., 1967	Jacksonville
General Practice A. MACKENZIE MANSON, M.D., 1965— Internal Medicine	Jacksonville
FRED A. BUTLER, M.D., 1964	Tallahassee
Neurosurgery THOMAS E. SCOTT JR., M.D., 1966	Daytona Beach
Obstetrics and Gynecology ARTHUR J. WALLACE, M.D., 1965	
Onlithalmology and Otolaryngology	1 ampa
Ophthalmology and Otolaryngology JOHN H. WEBB JR., M.D., 1965	Orlando
Orthopedics EDWARD W. CULLIPHER, M.D., 1967.	Miami
Pathology	bitamt
SANFORD A. MULLEN, M.D., 1964	Jacksonville
J. K. DAVID JR., M.D., 1964	Jacksonville
Plastic Surgery BERNARD L. N. MORGAN, M.D., 1965	Jacksonville
Psychiatry MARLIN C. MOORE, M.D., 1967	Lagheonnilla
Radiology	
IVAN ISAACS, M.D., 1964	Jacksonville
EMMET F. FERGUSON JR., M.D., 1966	Jacksonville
DAVID W. GODDARD, M.D., 1966	Daytona Beach
Subcommittee on Specialty Groups	
CHARLES H. BURKE, M.D.	Jacksonville
Florida Academy of General Practice WALTER L. SCHAFER, M.D.	
IAMES T. ATKINS, M.D.	Jacksonville
Florida Society of Anesthesiologists NELSON H. KRAEFT, M.D	Tallahassee
Florida Chapter, American College of	Chest Physicians
WILLIAM H. EYSTER JR., M.D.	Daytona Beach
Florida Society of Dermatology WILLIAM F. HILL IR., M.D.	Sebrine
WILLIAM F. HILL JR., M.D Florida Health Officers' Society LAWRENCE E. GEESLIN, M.D	
LAWRENCE E. GEESLIN, M.D. Florida Society of Internal Medicine	Jacksonville
Pioriaa Society of Thiernal Meatine	

DAVIS H. VAUGHAN, M.D	Clearwater
Florida Obstetric and Gynecologic	Society
Florida Obstetric and Gynecologic BERNARD M. BARRETT, M.D.	Pensacola
Florida Society of Ophthalmology an	d Otolaryngology
GEORGE 1. RAYBIN, M.D.	Lacheowilla
Florida Orthopedic Society	Jucksonville
	T1
SANFORD A. MULLEN, M.D.	Jacksonville
Florida Society of Pathologists	-
OLIVER F. DEEN JR., M.D.	Tampa
Florida Pediatric Society	
W. C. FLEMING, M.D.	Coral Gables
Florida Society of Physical Medicine	and Rehabilitation
JOHN M. HAMILTON, M.D.	St. Petersburg
Florida Society of Plastic and Recons	tructive Surgery
JOHN R. BUTTER, M.D.	St. Petershuro
Florida Proctologic Society	
WILLIAM C. RUFFIN JR., M.D.	Cainesville
Florida Psychiatric Society	Gamesville
DAVID KIRSH, M.D.	Minni
Florida Radiological Society	
HADDY III DEINGTINE ID M.D.	Y 7
HARRY W. REINSTINE JR., M.D.	Jacksonville
Florida Chapter, American College of	Surgeons
JOHN H. TERRY, M.D. Florida Association of General Surge	Jacksonville
Florida Association of General Surge	ons
FRED H. ALBEE JR., M.D.	Daytona Beach
Florida State Surgical Div., Int'l Co	llege of Surgeons
ROBERT J. BROWN, M.D.	
Florida Urological Society	, ackson vitte
- tortage or orogical bottery	

COUNCIL ON VOLUNTARY HEALTH AGENCIES

MASON ROMAINE III, M.D., Chm.	Jacksonville
MASON ROMAINE III, M.D.	Jacksonville
WOODS A. HOWARD, M.D. Arthritis and Rheumatism Foundation	Lakeland
C11ARLOTTE C. MAGUIRE, M.D Fla. Society for Crippled Children and Adults	Orlando
EARL E. WILKISON, M.D. Fla. Division, American Cancer Society	
FRANK L. CREEL, M.D. Florida Association for Mental Health	Pensacola
IAWLEY H. SEILER, M.D. Florida TB and Health Association	Татра
RICHARD G. SKINNER JR., M.D.	Jacksonville
National Foundation THOMAS S. EDWARDS, M.D. Florida Society for Prevention of Blindness	Jacksonville

FLORIDA MEDICAL FOUNDATION

LEO M. WACHTEL, M.D., Pres	Jacksonville
S. CARNES HARVARD, M.D.,	Vice Pres. Brooksville
HENRY J. BABERS JR., M.D.,	Sccy-TreasGainesville

INVESTMENT PLAN COMMITTEE

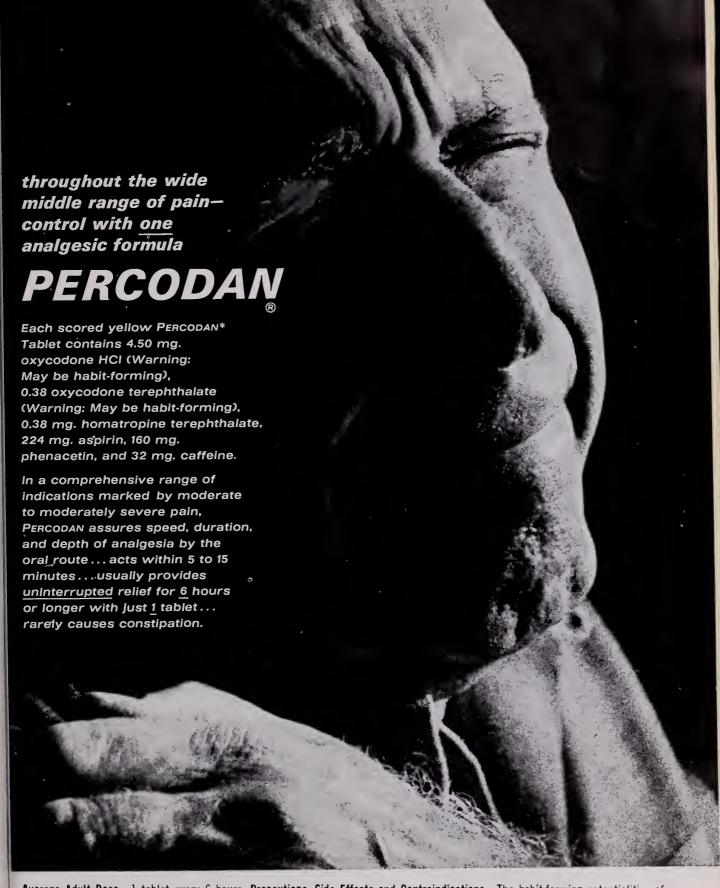
FLOYD K. HURT, M.D., Chm.	Jacksouville
SAMUEL M. DAY, M.D.	Jacksonville
BURNS A. DOBBINS JR., M.D. Fort	
EDWARD JELKS, M.D.	
NORVAL M. MARR SR., M.D. St.	
CARL S. McLEMORE, M.D.	Orlando
JOHN D. MILTON, M.D.	oral Gables
WILLIAM M. C. WILHOIT, M.D.	Pensacola

LEGAL COUNSEL

MARKS, GRAY, YATES, CONROY & GIBBS Jacksonville

CERTIFIED PUBLIC ACCOUNTANTS

LUCAS AND HERNDON....... Jacksonville



Average Adult Dose—1 tablet every 6 hours. Precautions, Side Effects and Contraindications—The habit-forming potentialities of Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, Percodan may cause nausea, emesis, or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. Also available: Percodan®-Demi, containing the complete Percodan formula but with only half

the amount of salts of oxycodone and homatropine. Both products are on oral Rx in all states where laws permit.

Narcotic order required. Literature on request.

ENDO LABORATORIES Richmond Hill 18, New York



INDEX TO ADVERTISERS



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets before meals and at bedtime. Individualization required.

Supplied: Bottles of 50 tablets.

CML-9646

Miltrate[®]

meprobamate 200 mg.+ pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / Cranbury, N. J.

Anna Ca Ina	COL 1
• Ames Co., Inc.	
Anderson Surgical Supply Co.	
Appalachian Hall	
Arnar-Stone Laboratories	
Ballast Point Manor	
Brawner Hospital, Inc.	
Brown Pharmaceutical Co.	
Burroughs Wellcome & Co.	
Chatham Pharmaceuticals, Inc.	
Coca-Cola Co.	
Convention Press	
Davies, Rose & Co	
Dorsey Laboratories	
Duvall Home	
Endo Laboratories	
J. H. Filbert, Inc.	
Geigy Pharmaceuticals	
Hart Laboratories	
Hill Crest Sanitarium	
Lederle Laboatories	
Eli Lilly & Co.	
Medical Protective Co.	
Medical Supply Co.	
Meridian Building	
Parke Davis & Co.	
Physicians Products Co.	
P. L. Dodge Memorial Hospital	and the second of the second s
PM of Florida	
Roche Laboratories	
William H. Rorer, Inc.	
Ross Allen Institute	
Sanborn Company	
W. B. Saunders Co.	
Saron Pharmacal Corp.	
Schering Corp.	
G. D. Searle Company	
Smith, Kline & French	
Standard Brands, Inc.	
Surgical Supply Co	
S. J. Tutag & Co.	
Tucker Hospital, Inc.	
U. S. Vitamin & Pharmaceutical C	
Bob Wagner X-Ray	
Wallace Laboratories	
Westbrook Psychiatric Hospital, In	
Winthrop Laboratories	420, 465

INDEX

VOLUME 50, 1963

can be found at end of v.51,1964





Morris A Price 3305 Hendricks Ave Jacksonville 7 Fla

anxie anxie

anxiety anxiety anxiety

anxiety anxiety

anxiety

anxiety anxiety

anxiety reduced to its proper perspective

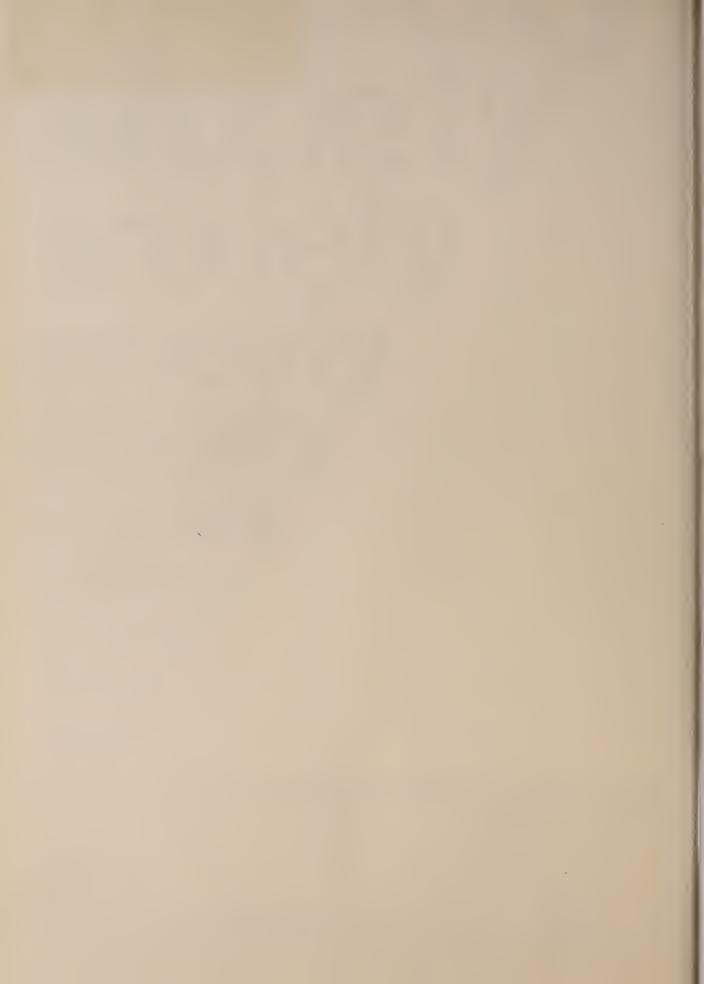
Librium (chlordiazepoxide HCI) the successor

to the tranquilizers



In prescribing: Dosage — Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatri patients: 5 mg b.i.d. to q.i.d. Cautions — Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment. Caution should be exercised in prescribing any therapeutic agent for pregnant patients. Supplied — Capsules, 5 mg, 10 mg and 25 mg, bottles of 50 and 500.







The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER
	•
`	



